Schizophrenia and Violence From the Families Perspective

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ABSTRACT

While current research may have established a relationship between mental illness and violence it has failed to consider the context in which violence occurs. A questionnaire was designed to determine, the extent and kind of violence brought about by schizophrenia, how it effected the families of those with the illness, and how these families coped. The questionnaire, which was sent to all family members of the Schizophrenia Fellowship of New Zealand (1038), yielded a 42% response rate. Violence was present in three quarters of returns. Violence was most often expressed in the form of threats or threatening type behaviour. Violence was also directed at property, persons, and self. Family members were more often the victims of physical attack than the general public. Most of those with schizophrenia were psychotic when violent. Alcohol and/or drug abuse but mainly non-compliance with medication figured as precursors to violence. Family members were affected physically and psychologically by violence and used a variety of strategies for coping. They most often enlisted the help of others to try and diffuse the situation. In conclusion, the implications of the research are discussed, the need for future research is justified, directions for future research are suggested, and concluding comments are made.

INTRODUCTION

The relationship between mental illness and violence is considered from public, media, and academic viewpoints. Then follows an explanation of how schizophrenia and violence relates to families in terms of a shift in the burden of care which has made them increasingly vulnerable to violent behaviour. The fact that schizophrenia related violence has not been studied from a family perspective is raised. Reasons why current research methodologies are not applicable to the study of violence in relation to the relatives of those with schizophrenia are considered. The need for adequate research from a family perspective is given. Finally, a statement of objectives for the study of schizophrenia and violence from the families perspective is made.

Schizophrenia and Violence

The belief that mental disorder is conductive to violence runs deep in western culture, but is by no means peculiar to it (Monahan, 1992). Throughout history and in all known societies people have believed that mental disorder and violence were somehow related. References in Greek and Roman literature to the violence potential of the mentally disordered date from the fifth century BC (Monahan, 1992).

Public Perceptions

The lay public has a deeply rooted fear of the mentally ill. Integral to the ordinary person's point of view is a loss of self control, disturbed, unpredictable and violent behaviour. This stigma is persistent across all social groups and attitude measures (Nunally, 1961). Trute (1989) found no significant differences in levels of public rejection in research conducted much later. Eker (1989) states that the attitudes toward the mentally ill are still, in general, negative.

Link et al. (1987) investigated the extent to which a person's status as a former mental patient fostered social distance on the part of others. They found no main effect of the former patient label. However, subjects who believed in a link between mental illness and violence strongly rejected and wanted to distance themselves from the former patient.

Media Perceptions

Unfortunately, the occasions when people become most publicly aware of schizophrenia are those during which someone with the disease commits a violent act (Torrey, 1983). The media often helps foster the view that the mentally ill are potentially dangerous by highlighting extreme instances. This was demonstrated by Shain and Phillips (1991 (Cited in Monahan, 1992, p.513)). They found in a content analysis of stories from the United Press International database that violent crime was the focus of 86% of articles dealing with former mental patients.

Academic Perceptions

Monahan (1992) states that the consensus of modern academic opinion has been that there is no relationship between mental illness and violence. He adds that new studies - by no means perfect, yet by all accounts vastly superior to what had been in the literature even a few years ago - find a consistent, albeit modest, relationship between mental disorder and violent behaviour.

Yesavage et al. (1983) found people with schizophrenia to be four times as violent as the general population. Lindqvist and Allebeck (1989) noted that the rate of violent offending among people with schizophrenia was up to four times that expected. In Tardiff's (1989) study more than 10% of psychiatric patients who had been hospitalized had been violent towards other persons. Mullen (in press) notes that such findings do raise questions of their explanation, if not some anxiety.

Though there is a considerable body of empirical evidence bearing on whether those with schizophrenia are more prone to violent behaviour, the assessment of this literature is fraught with so many difficulties that it is still possible for well informed reviewers to come to diagnostically opposed conclusions (Mullen, 1991). The accumulated results in the literature to date present inconsistent findings on just about every demographic variable that has been studied. For a topic of such fundamental importance the existing research is remarkably shallow (Rossi et al., 1986).

Most literature dealing with schizophrenia and violence has been concerned with the prediction of violent behaviour of hospitalized psychiatric patients. Although, one would think that pushing large numbers of patients out of care into the community is slowly changing the situation. In a research review, Monahan (1982) found prediction of violence without accuracy. Psychiatrists and psychologists were successful in only one of three predictions of violent behaviour. Across the body of research, estimates of the prevalence of violence range widely based on different time intervals and criteria for assessing violence (Swanson et al., 1990). Leggatt (1989) contended that prediction of violent chargeable acts was unable to be carried out with enough accuracy to warrant involuntary hospitalization on the basis of possible future violence alone.

Whether those with mental illness are more violent than the general public is still an issue of contention throughout the literature. It is not a question easily resolved or one that will be addressed directly in this thesis. Such information is considered of little help to the families and people who live with schizophrenia.

There is however, consensus in psychiatric literature that people within certain groups of the mentally ill present an increased risk of violent behaviour (Wessely & Taylor, in press (Cited in Mullen, in press)). The

diagnosis most often associated with violence is schizophrenia or schizophrenic disorders (Krakowski et al., 1986; Straznickas, 1993). For schizophrenia the DSM-111-R (American Psychiatric Association, 1987) lists violent behaviour as an associated feature. Although not a necessary symptom, violent behaviour increases the likelihood that the diagnosis will be given (Swanson et al., 1990).

Schizophrenia and Violence in relation to Families

A Shift in the Burden of Care

The way in which society has cared for the mentally ill has been through a series of sharp reversals. Families were originally responsible for their relatives before a movement in the 19th and early 20th centuries led to institutionalized care. By the late 1950's home and community were once again favoured and the mentally ill were rapidly deinstitutionalized. Figure one graphically illustrates the dramatic decrease in available beds at a major institution (Sunnyside Hospital, Christcurch, New Zealand).

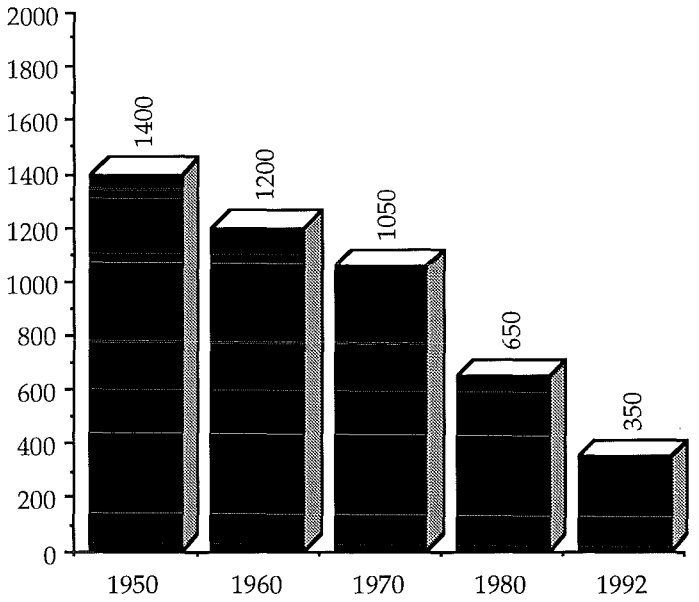

Figure 1. Sunnyside Hospital bed availability
Source : Canterbury Area Health Board Mental Health Series, 7 Aug.1992.

This mass exodus from mental hospitals and institutions resulted from the invention of neuroleptic drugs in the mid-1950's. These drugs helped substantially quell the more florid symptoms, of illnesses such as schizophrenia, to manageable levels. The first patients to leave were those who had the least necessity to be living in an institution and whose requirement for community social support was not as great as those discharged later.

Deinstitutionalization was further fuelled by the realization that the large institutions of the era were not the best for care as the attitudes and habits which the patients became accustomed to over the years would progressively reduce their chances of re-adapting. Civil libertarians also fought to give the mentally ill more powers of freedom.

For some life has been transformed but many of those deinstitutionalized

have been placed into communities that lack the knowledge and resources to provide adequate care. They may be to ill to fend for themselves and face the possibility of loneliness, homelessness, isolation, exploitation, victimization, crime, despair and undue stress, all of which exacerbate psychotic illness.

Consequently, the relationship between people with schizophrenia and their families has changed dramatically. Family members are ever increasingly involved with their relatives, often as primary caregivers, in all but the most acute phases of their illness.

Minkoff (1978) reported that as many as 65% of discharged mental patients went to live at home with spouses or parents. Goldman (1982) found that 73% of mental patients admitted to general hospitals had been living with family prior to their admission but that 50-75% was a more accurate estimate for those with schizophrenia.

Families Have Become Targets of Violence

Deinstitutionalization, fuelled by a lack of adequate community care, has increased the exposure of family caregivers to violence from relatives with schizophrenia. Leggatt (1989) has suggested that serious acts of violence have been occurring as patients are abandoned by psychiatric services (Figure 2).

Furthermore, research has found that family members are more likely than the general public to suffer the consequences of violent behaviour from relatives with schizophrenia (Straznickas, 1993; Mullen, in press). People who suffer from schizophrenia may be gentle and mild but their disturbed perceptions can turn them against their family who becomes part of their psychotic episodes and an obvious target for violence if they suffer violent delusions. They may blame the family for the cause of their illness, in one way or another, and routinely act more abusively and ineptly towards their family than they do other people.

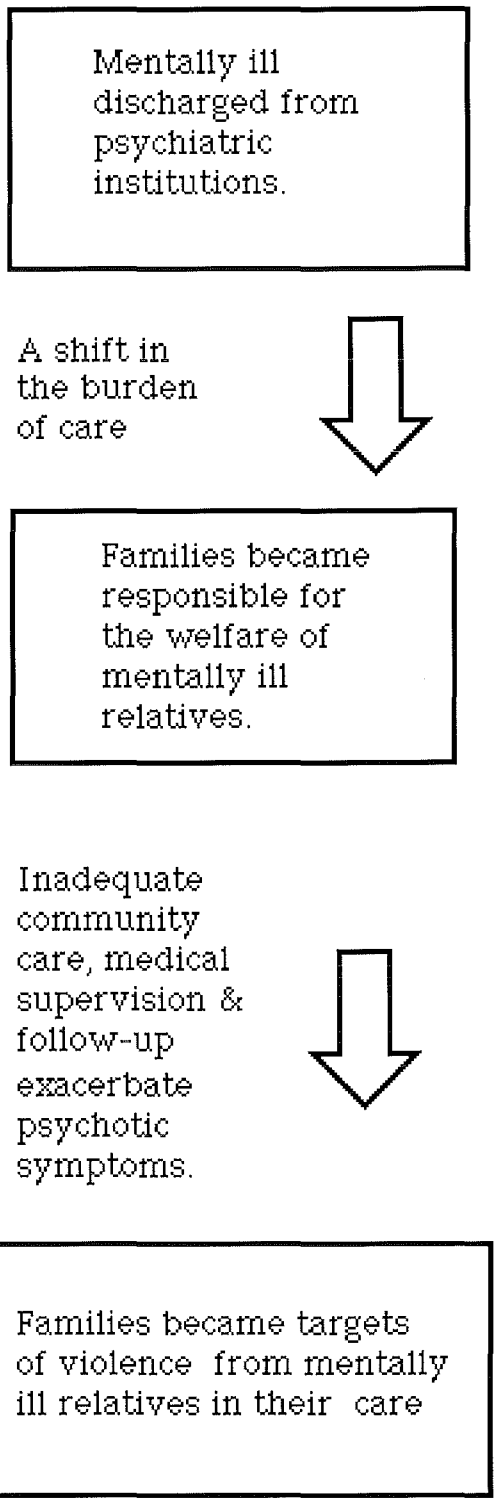

Figure 2. Families have become targets of violence.

The Family Perspective has been Ignored

While the relationship between mental illness and violence has been well documented over the years, little of the research has sought to examine violence in relation to the relatives of those with schizophrenia. Although it has been recognized that families pay a high price (Grad & Sainsbury, 1963), understanding their plight has been seriously neglected (Leggatt & Carey, 1987).

Research that has addressed the issue of violence committed by the mentally ill has been primarily concerned with determining its incidence and defining offender characteristics to predict future violence. Studies of violence in psychiatric patients have neglected the situational factors such as the interpersonal context in which this behaviour occurs. The few investigations that have addressed this issue suggest that family members are the most likely targets (Planansky & Johnston, 1977; Virkkunen, 1974; Chuang, 1987), or at high risk of becoming victims of violence from relatives with schizophrenia (Binder & McNiel, 1986).

Leggatt (1989) in a review of relevant literature noted that, although the survey was far from complete, nowhere were there any data or references to what families might be facing or having to cope with by way of violent behaviour from their mentally ill relatives. Swan and Lavitt (1988) state that this particular type of domestic violence has received little empirical investigation and the full extent of such behaviour amongst those with schizophrenic disorders living in the community has still not been adequately documented.

Family Accounts are Important and Unique

Families have little difficulty in assessing when a relative is becoming unwell or entering a psychotic phase of the illness with an increased probability of violence (Tait, 1991a). Such problems almost always have forewarnings

through threats and other signs of impending trouble (Torrey, 1983). For this reason, the observations of family and agency workers can be more accurate than those of psychiatrists who see their patients intermittently (Tait, 1991b).

Violence does not always result from an acute or psychotic phase of the illness or when symptoms of schizophrenia first become apparent. Family members may experience violence as minor bouts of aggression that can accompany a person who is reasonably well medicated. Therefore, caregivers perceive violence differently to the medical profession or general public.

Family accounts are unique in the sense that most reports of mental illness are written, as it were, from the outside looking in by social workers and doctors who inevitably see the family for a small portion of its time and their time. By contrast family descriptions are written by relatives involved in one way or another with schizophrenia all the time.

Family Accounts are Seldom Heard

Family accounts are seldom heard because families are generally unorganized, shy of publicity, and some are rather broken by their experiences (National Schizophrenia Fellowship, 1975). Also, a sense of guilt has been created by theories which looked for dynamic forces capable of creating schizophrenia from the mother (Fromm-Reichman's 'Schizophrenogenic Mother,' 1948) or as a manifestation of the entire family. In "Expressed Emotion Theory," families are faced with the notion that they are the pathological agents in maintaining mental illness (Hatfield, 1987a).

Leggatt and Carey (1987) suggest that families may understate and problems they have with mentally ill relatives for a number of reasons. Families may adjust their level of expectation so that after a period of years they no longer react according to earlier hopes for their relatives or have forgotten what they were. A sense of duty pervades which makes relatives, especially mothers,

willing to undergo considerable distress, discomfort, or embarrassment without complaint. Also, the condition fluctuates. If the situation is calm, previous events may appear tolerable or lose their urgency.

Current Research Methodologies

Current research methodologies are not well suited to the investigation of schizophrenia related violence from a family perspective. That is, the type of violence families are experiencing, how violence affects families, and how families cope with violence.

Institutional Research

Most research on schizophrenia and violence is conducted in institutions. The generalizability of these findings to other geographic settings, like the community, cannot be readily assumed (Tardiff & Koenigsberg, 1985). According to Chuang (1987) and Buckley et al. (1990), results from studies carried out in various clinical situations have shown inconsistent findings.

Also, information from institutions is not relevant because of the contrasting staff/patient, family/relative relationship. An institution does not evoke the same emotional link. Therefore, actions in dealing with people do not have the same emotional consequence for both parties.

Time Frame

The evaluation of violence throughout the course of the illness is important as results from studies carried out over alternative time frames have been inconsistent (Chuang, 1987; Buckley et al., 1990). Binder and McNiel (1986) assessed violence only two weeks prior to hospital admission. Patients may have exhibited violent behaviour during a period of relapse and ceased to be violent on hospitalization.

Definition of Violence

The definition of violence employed in many studies is often very narrow. Estimates of the prevalence of violence among those with schizophrenia vary according to the definition of violence employed (Buckley et al., 1990). Often studies only define violence as physical assault. Tardiff and Koenigsberg (1985), and Binder and McNiel (1986) did not include self-injury, damage to objects, or verbal threats, as examples of violence.

Otto (1992) suggests that the base rate of violent behaviour among mentally ill people in the community, who come to the notice of criminal justice or mental health professionals, ranges from 10-30% depending on the definition employed.

Reporting of Violence

Few assaults are formally reported in mental hospitals (because of the effort required to fill out an accident report, took it as a matter of course, reporting represented a performance failure) and especially in the family situation (Kay et al., 1988a). For this reason, studies that rely on offences coming to the notice of the police, as in a charge/prosecution or formal hospital report, do not provide an accurate representation. Furthermore, the mentally ill may be more liable to detection when they do offend.

Sampling

The literature on mental disorder and offending often treats the mentally disordered as a single entity. Even when distinctions are made between different diagnostic groups, the basis for such distinctions is often unclear or confusing. Chuang (1987) and Buckley et al., (1990) found results from studies carried out using different diagnostic groups of the mentally ill to give inconsistent findings. According to Mullen (in press), the standards of diagnostic practice now considered mandatory in other areas of research

concerning schizophrenia have yet to enter this field.

Reporting

If studies of violent behaviour are by peoples own admission, response biases can account for people answering in what they think is a socially desirable way. Family or staff observations are superior to self report questionnaires for this reason.

The Need for Research

"From the kind of family situations with which we are being confronted in the Schizophrenia Fellowship we have sound reasoning for wanting the issue of schizophrenia and violence to be addressed more forcefully..... more and more violence is being experienced in family environments, violence which is related to the symptoms of mental illness (Leggatt, 1989)."

Ten years ago it was widely believed that people with schizophrenia were seldom violent but it was slowly becoming apparent that things were not quite as had been thought. In fact, there was a lot of unacceptable illness related behaviour. Members of the Schizophrenia Fellowship would look at the windows and furniture smashed by their relative with schizophrenia and wonder if his/her diagnosis was accurate (Tait, 1991a).

At its annual conference in May 1991 the Schizophrenia Fellowship (N.Z) Inc. unanimously passed a notion that a working party be set up to investigate the feasibility of a research study into the extent and kind of destructive behaviour brought about by schizophrenia. There was general agreement on the need for research into the subject and for the compilation of accurate data.

Gondolf (1990) noted that a systematic investigation of violence toward family members was essential for the understanding of violence by the mentally ill.

OBJECTIVES

A lack of relevant research severely limits the drawing of any firm hypotheses based on these studies. Therefore, this thesis adopts an exploratory and qualitative approach to the study of schizophrenia and violence.

While recognizing the methodological limitations of previous research, as discussed, and the fact that it has generally ignored the context in which violence has occurred, they have been utilized as references to indicate general trends.

The intention of the thesis is to examine schizophrenia and violence from the families perspective by pursuing the following objectives;

The Extent and Kind, and Frequency of Violence

The objectives are to determine .....

Extent

..... how widespread violence related to schizophrenia is.

Kind

..... what type of violence families are facing. Are threats made? Is violence directed at property, at others or self?

Buckley et al. (1990) noted that family property was at risk as violence in the home involved episodes of damage to furniture. Buckley et al. (1990) also suggest that most acts of violence were of a minor nature as they observed serious physical assault in only 1% of cases in their study of hospital inpatients.

Suicide among people with schizophrenia is not uncommon. Torrey (1983) and Mullen (1991) estimate the chance of suicide at 10%, which is 17 times

greater than the general population.

Also, Mullen (1991) estimated the chance of homicidal attack at 0.05%.

Frequency

..... how often violence occurs. Is it isolated, episodic, or ongoing?

The Characteristics of those with Schizophrenia who are Violent

The objectives are to determine .....

Age first violent

..... the average age that those with schizophrenia were first violent.

Sex differences

..... the percentage of males and females with schizophrenia who are violent and if the percentage of males and females are different between violent and non-violent samples.

Schizophrenia is a somewhat different disease in men than in women (Seeman, 1983a). Men with schizophrenia have an inferior response to treatment and generally poorer prognosis (Seeman, 1982). Krakowski et al. (1986), Tardiff (1984), and Tardiff and Deane (1980) found males to be generally more violent. Conversely, Blomhoff et al. (1990) found no sex difference in groups of psychiatric inpatients.

Comparisons with the Non-Violent

..... if the age of onset of schizophrenic symptoms and the diagnosis of schizophrenia for those that are violent is different to those that are not violent.

Swan and Lavitt (1988) and Buckley et al. (1990) found no significant difference

for the age of onset for violent and non-violent individuals .

..... if the length of time between the development of schizophrenic symptoms and medical intervention is different for violent and non-violent individuals.

Patients whom there is a delay of 6-12 months after the onset of symptoms before they begin treatment do less well than those who start treatment earlier in the course of their illness (Silverstone, 1993; Mullen, in press).

Change in violence with age

..... if there is any change in violent behaviour with age.

Straznickas (1993), Buckley et al. (1990), Swanson et al. (1990), Kay et al. (1988a), Swan and Lavitt (1988), Roy et al. (1987), Krakowski et al. (1986), Tardiff and Koenigsberg (1985), and Tardiff and Sweillam (1982) all found younger people with schizophrenia to be more violent.

When and Why Violence Occurs

The objectives are to determine.....

State of mind

..... the state of mind that those with schizophrenia are in when violent.

Mullen (in press) in a review of studies found most subjects were psychotic when violent. Planansky and Johnston (1977) suggested that all homicidal violence occurred during active phases of psychosis, typically in a setting of acute excitement and in recurrent relapses. The connection between the homicidal urge and active psychosis, as evidenced by hallucinations, delusions and peculiar thought processes, has been generally acknowledged (Hamilton, 1976). Torrey (1983) noted that for violence against oneself, in the form of suicide or self-mutilation, almost all people are very psychotic at the time.

In contrast, Virkkunen (1974) found only slightly over a third of the acts of violence were committed during a psychotic episode. He concluded that not all violent acts of people with schizophrenia are to be regarded as the result of a psychosis.

Alcohol and drug use

..... if the use of drugs and/or alcohol contributes to violence among people with schizophrenia.

In research by Feinstein and Plutchik (1990), Swan and Lavitt (1988), and Blomhoff et al. (1990) drugs and/or alcohol increased violence in psychiatric inpatients. Torrey (1983) noted that many attacks of violence occurred in those who were using street drugs and/or alcohol. According to Swanson et al. (1990) alcohol and drugs are a lethal mix for those with schizophrenia.

Compliance with medication

..... if the taking of medication represents a problem for many.

Non-compliance with medication increases violence and makes the relapse risk high (Swan and Lavitt, 1988). Torrey (1983) found that most physical violence occurred in those who were under-medicated or unmedicated. Krakowski et al. (1986) found acts of aggression decreased in frequency as patients responded to medication.

Family contact

..... if the amount of contact families have with their mentally ill relatives affects their relative's violent behaviour.

Pattern of violence

..... if families can recognize any pattern to their relative's violent behaviour.

Who the Violence is Directed at

The objectives are to determine.....

Family or non-family

..... whether family or non-family are more likely to suffer the consequences of violent behaviour from a relative with schizophrenia.

Straznickas (1993) in a review of existing studies suggested about half the victims of violence were family members as did Tardiff Koenigsberg (1985), Tardiff (1984), and Mullen (1984). Mullen (in press) found that the victims of killings perpetrated by those with schizophrenic disorders were even more likely to be members of their immediate family than with mentally competent offenders. In the research of Planansky and Johnston (1977) victims of psychotic murders were mainly spouses, relatives and other persons close to the offender. Turkat and Buzzell (1983) linked recidivism to hospital with violence against the family. Violence by recidivists was directed mainly at the family and not others in the community. Binder and McNiel (1986) found 54% of violent patients (15% of all patients) had assaulted a family member prior to admission.

Violence directed at one person

..... whether the violent behaviour of someone with schizophrenia is directed at one person in particular.

Often delusional thoughts will have developed while growing up in the family situation and be directed at those with whom people with schizophrenia had most contact, especially mothers (Straznickas, 1993). Packham (1978) found that the young schizophrenic may present a real threat towards his parents, particularly the mother. Planansky and Johnston (1977), Straznickas (1993), Swan and Lavitt, 1988, Gondolf (1990), Blair (1991), Monahan (1982), and Tardiff (1984) found women almost twice as likely to be

targets of violence than men. Buckley et al. (1990) showed that the majority of violent acts were directed towards close female relatives.

The Effects of Violence on Families

The objectives are to determine.....

Financial, health, psychological, and relationship effects

..... the effects violence from a relative with schizophrenia has on families.

Violence in the form of verbal abuse, attacks on property and persons has a potentially devastating effect on family caretakers who must often live in chronically tense and fearful environments (Swan and Lavitt, 1988). There is often a pervasive fear associated with the likelihood of unpredictable outbursts and the possibility that further violence may occur (Hatfield, 1987b). Fadden et al. (1987) also found that coping with relatives' problems frequently resulted in adverse effects on family members physical and psychological well being. The ambivalence inevitably felt by the family members is formidable; fear and love, avoidance and attraction (Torrey, 1983).

Self destructive and suicidal behaviour is especially distressing to families (Rollin, 1980). It can generate profound feelings of anxiety, helplessness, anger, guilt, and concern (Hatfield, 1987b).

How Families Cope with Violence

The objectives are to determine.....

Coping

..... the strategies that families use for coping with their relative's violent behaviour.

Most disturbing and difficult type of violence to deal with

..... the type of violence families find most disturbing and difficult to deal with.

Malone (1991) proposed that the public violence at the time of committal was easier to live with than the ongoing hidden internal aggression which the family had to cope with day to day.

Satisfactory community care

..... whether families find the standard of community care adequate for their mentally ill relatives.

METHOD

The respondents to the study are described. The research design is outlined, followed by an account of the sampling procedure. The questionnaire is then detailed; its development and construction are discussed, psychometric properties specified, methodological considerations offered, and description given. Ethical issues, including informed consent, sex fairness, and the stigmatization of those with schizophrenia, are documented. The procedure in administrating the questionnaire is then demonstrated, proceeded by a summary of the pilot study.

Respondents

Respondents were 1038 family members of the Schizophrenia Fellowship of New Zealand (Inc.). The Schizophrenia Fellowship is a national and international network providing information, guidance, and social support for people with schizophrenia and their families. The Fellowship offered an accessible subject base to work from as an association with the organization had been established over the last three years in a voluntary role.

The primary caregivers of people with schizophrenia were targeted because they could provide a detailed account of their mentally ill relative's behaviour. Straznickas (1993) noted that proximity and the caretaking role, rather than simply the kinship type of relationship with the patient, was a salient factor affecting which family members became victims when patients became violent.

Respondents were encouraged to consult with other family members in the completion of the questionnaire.

Design

Essentially non-experimental, the design was a two criteria group field study. Behaviour was not manipulated in any way and respondents fell into naturally occurring groups. That is, they were not randomly assigned to levels of the independent variable. The respondents to the questionnaire were related to people who fell victim to a mental illness and were not selected by any controlled sampling procedure. Therefore, gender, regional location, age, etc., were not selection criteria. The only two criteria were family membership to the Schizophrenia Fellowship of New Zealand and having a relative with schizophrenia.

Sampling

The nuances of behaviour may be lost in a matter of words and questionnaires may also highlight a transitory state. However, a mailed out questionnaire was chosen because of the convenience in reaching a large number of people. Furthermore, aspects of the questionnaire were felt to be exceedingly personal or sensitive for an interview situation. Leggatt and Carrey (1987) suggested that relatives often found it hard to discuss intimate details with a researcher. A better response was anticipated to an anonymous questionnaire for this reason.

All family members (members with relatives who have schizophrenia) belonging to the Schizophrenia Fellowship were selected on computer from the membership database (The total family membership was 1044). Six members living overseas were not included as a considerable time delay was anticipated in any correspondence. This left 1038 potential respondents to the questionnaire.

The Questionnaire

Development and Construction

A questionnaire was constructed specifically for use in the current study (Appendix A). Initial suggestions and guidance came from the working party on schizophrenia and violence mentioned in the introduction. All members of the working party had relatives with schizophrenia and could provide invaluable knowledge from personal experience.

Any changes or recommendations were made to questionnaire drafts by the researcher and members of the working party until a satisfactory article was produced. The final inventory consisted of nine sections including questions in a closed and open-ended format. The qualitative aspects of the questionnaire allowed respondents to provide information in more detail than closed format questions. Each section dealt with different aspects of schizophrenia and violence.

An extensive literature review revealed that the questionnaire was different from previous questionnaires on violence in relation to schizophrenia. Other researchers such as Kay et al., (1988a & 1988b) and Plutchik and Praag (1990) developed and used scales which were weighted and therefore predictive of violence. Their questionnaires were also conducted in institutions, of a self-report nature (person with schizophrenia fills out), and over a specified observation period. The present questionnaire's purpose was not for prediction of violence. It was designed to find out how family members are affected by and cope with violence from a relative with schizophrenia as well as examining the extent and kind of this behaviour. The questionnaire was to be filled out by a relative(s) of the person with schizophrenia over a non-specified observation period. In that way any relevant event in their life could be included even before a diagnosis of schizophrenia had been made. Also, if people with schizophrenia had disassociated themselves with their family,

members could recall instances of violent behaviour when their relative was living with them or associated with them.

Violence was not limited to recorded acts, criminal convictions, or physical attacks as other questionnaires on schizophrenia and violence have been (refer introduction). Torrey (1988) described three types of violent behaviour that people with schizophrenia might commit. The destruction of property, violence against others, and violence against oneself. These types of violent behaviours, along with threats of violence, were adopted in the definition of violence for the questionnaire.

Violence does not need to include physical action because threats or menacing behaviour alone can create stressful and frightening situations for families. The fear is in the uncertainty of not knowing how or when such threats or behaviour will erupt into actual violence (Leggatt, 1989).

Psychometric Properties and Methodological Considerations

All sections of the questionnaire were checked for face validity and comprehensibility by the author and working party on schizophrenia and violence.

The intention of the study was not to establish cause-and-effect relationships (between schizophrenia and violence) as causality was not required to document a relationship or discover an association between variables. Of more central concern were the accurate measurement of constructs and the collection of data from a significant sample of individuals (external validity). Field research is less valid than experimental methods only if one defines internal validity solely in terms of testing cause and effect relationships. If internal validity is defined as the extent of which research procedures enable one to draw reasonable conclusions, then it is no more or less valid than any

other method.

External validity is the extent to which data may be generalized beyond the research project and to a certain extent depends on how well the sample is chosen. In this case, whether or not the sample is representative of all family members who have relatives with schizophrenia. Sampling from those who suffered the consequences of violence from a relatives undiagnosed or misdiagnosed schizophrenic symptoms represented an impossibility. Also, those who were outside of the Schizophrenia Fellowship and had a relative with schizophrenia were not included. The last point raises several issues worthy of discussion. Families who come to such a fellowship maybe biased towards the more severe forms of schizophrenia, or those forms which manifest with violent behaviours (Leggatt, 1989). Seeman and Hauser (1985) also suggested that most organizations of this kind were composed of families of patients with young males since early onset and male gender are associated with a poor prognosis in schizophrenia. Early onset may also increase families feelings of responsibility and guilt which combined with the fear of violence may promote the need for membership to support organizations (Seeman, 1983b).

However, the Schizophrenia Fellowship offered a lot of families coping with extremely difficult, tense, and anxiety producing situations revolving around the potential, if not the actuality, of violent acts (Leggatt, 1989). Members may have been more well adjusted because of the support such an organization gave.

Questionnaire Description

The first page of the questionnaire was a brief but informative introduction. Its aim was to interest and encourage respondents to fill out the questionnaire. It also offered reassurance and served to justify the research. Nine separate sections followed.

Items concerning age, gender and other demographic variables relating to the respondents relative were covered in section one. This section was to be to be completed by all respondents. Such information was important to gain an overall impression of the number of people with schizophrenia who are violent. Respondents with relatives that had never been violent were not required to fill out any more of the questionnaire.

Section two of the questionnaire dealt with threats of violence, section three with violence against property, section four with violence against persons, and section five with violence against oneself. Each of these sections asked respondents to indicate which behaviours their relative had exhibited by ticking boxes adjacent to a list of behaviours. Examples of representative behaviours were used to define the categories and guide respondents in gauging severity. They were also required to circle a number corresponding to the state of mind their relative was in at the time of the incident.

A separate part of each section allowed respondents to list any additional behaviours that their relative had exhibited that were not covered in the questionnaire. The last part of each section concerned the frequency of such behaviours. It required respondents to detail if their relatives behaviour was ongoing, episodic, made up of isolated instances, or something else.

Section four departed from sections two, three, and five by requiring respondents to make a family non-family distinction. They were to indicate whether violence against others was directed at family members or people outside the family.

Section six was in two parts. The first four questions related to medication, while the remainder concerned behavioural issues.

In section seven respondents were asked to list strategies they used for coping with the violent situations that arose.

Section eight required respondents to note the effects of violence on the family, physically, psychologically, and financially.

Section nine served as a comments section. Respondents were encouraged to include any additional information they felt relevant, note that an important issue was overlooked, or make general comments regarding the questionnaire.

Ethical Issues

Informed Consent

In line with University of Canterbury regulations each person that received a questionnaire was asked to complete a consent form (Appendix B). The consent form was accompanied by a covering letter from the director of the Schizophrenia Fellowship of New Zealand (Inc.) endorsing the questionnaire (Appendix C).

The purpose of the questionnaire and how the data would be used were outlined in the consent form and expanded upon in the introduction to the questionnaire. Results would be published in an upcoming Schizophrenia Fellowship newsletter monthly publication. The data generated by the present study would also be made available for further research and analysis.

Respondents anonymity was assured and questionnaire completion was voluntary. The strong support network of the Schizophrenia Fellowship was made available to those who wanted to discuss any aspect of the questionnaire, offer their support, or express an opinion on it.

Stigmatisation

Any research on schizophrenia and violence is an emotive issue. To argue for a connection between the two is to risk reawakening fear in the community with attendant demands for containment and, if a link between schizophrenia

and violence was accepted, could indiscriminately stigmatise all those who come into contact with the mental health services (Mullen, in press). In other words, if the violence associated with schizophrenia were talked about openly, the general public may think that all people with schizophrenia were violent. However, such a view is already widespread (refer to introduction). The community believes, even though it may be wrong, that people with schizophrenia are dangerous. After all, it is the predominant information they are given.

Denying that mental disorder and violence may be in any way associated is counter-productive. There are implications for mental patient advocacy, mental health law, and the provision of treatment. Information on the when and why of violent behaviour brought about by those with schizophrenia may also help dispel fears and misconceptions that could in turn lead to education and the development of preventative measures.

Procedure

Respondents were sent by mail a questionnaire entitled Schizophrenia and Violence, consent form, covering letter, and a pre-paid envelope with return address. Respondents were instructed to fill out the consent form and questionnaire and return them by the pre-paid envelope within a month of receiving them.

The release of the questionnaire coincided with Schizophrenia Awareness Week. This heightened awareness for the importance, relevance, and significance of the study.

The consent form and introduction page explained the purpose of the questionnaire. To maximise frankness the respondents were assured of confidentiality.

Each section began on a new page and at the beginning of each section brief but informative instructions were given explaining the items and how they should be filled out. It was suggested that the questionnaire would take 30-40 minutes to complete.

Pilot Study

A pilot study was conducted, with the full co-operation of the Christchurch branch of the Schizophrenia Fellowship, following the procedure already outlined.

The questionnaire was given to 10 local family members who had agreed to participate. The purpose was to bring to light any practical difficulties in completing the questionnaire. It also served to clarify the questions and highlight any areas in need of development or further investigation.

From the results it appeared the instructions were sufficiently clear to enable completion and questions were generally answered in the anticipated fashion.

Aesthetic alterations were made to the layout of the questionnaire due to some ambiguities experienced in the ticking and circling of boxes and numbers. Some questions were also reworked to clear up any uncertainty as to their meaning. A better measure of frequency was also included as the previous measure elicited a some what confused response.

Other minor changes did not result from the pilot study but came from further revisions of the content and purpose of the questionnaire. Information from the pilot study was not included in the final analysis.

RESULTS

The number of respondents to the questionnaire are presented. The extent, kind, and frequency of violent behaviour that respondents experienced from relatives with schizophrenia is discussed. Descriptions are then given of the people with schizophrenia, who were violent, in terms of sex, age, and illness related variables. When violence occurred, and the reasons why violence occurred, are described, followed by an account of who violence was directed at. The effects that violence from mentally ill relatives had on families are documented. Finally, the strategies that families used for coping are listed.

Response Rate

Of 1038 mailed out questionnaires, 431 were returned (41.52%). Of these 11 were returned blank because either the respondent's[1] relative had died or the relative had not been officially diagnosed with schizophrenia. A further 5 questionnaires were returned too late to be included in the study. Therefore, 415 questionnaires were used in the final analysis.

Refer to Appendix D for a profile of the total sample.

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[1] The "respondents" are the people who filled out the questionnaire. Their relatives, those with schizophrenia, are referred to as either the "total sample" (all respondents' relatives) or the "violent sample" (respondents' relatives who were violent).

The Extent, Kind, and Frequency of Violence

Extent and Kind of Violence

Violence in relation to the symptoms of schizophrenia was widespread. In all, 75.18% (312) of respondents reported that their relative had been violent, within the definition of violence given. Threats of violence were the most prolific as 88.78% (277) of the violent sample had threatened violence or acted in a threatening way. Of those, 65.38% (204) had been violent against property, 65.06% (203) had been violent against others, and 61.22% (191) had directed violence at themselves.

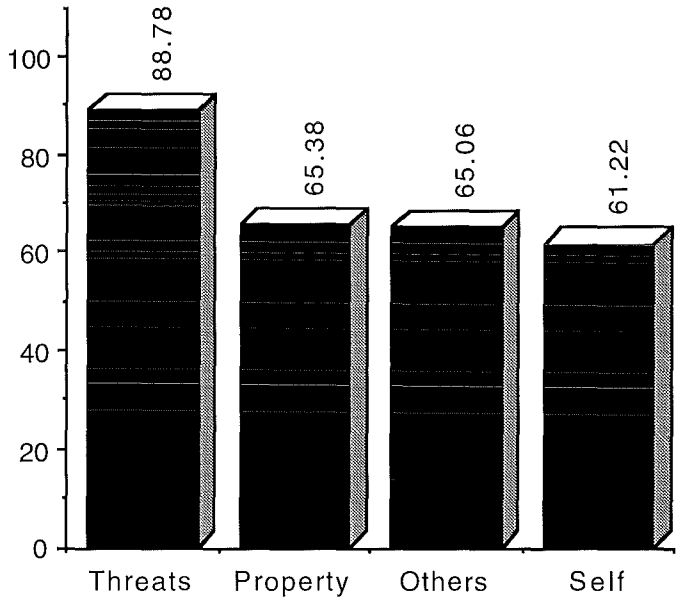

Figure 3. Types of violence[2].

[2] All graphs are expressed as percentages.

Threats of violence

In all, 88.78% (277) of the violent sample had made threats of violence. Of those, 71.48% (198) had made aggressive gestures including threatening postures, and clenched fists, 64.26% (178) had threatened to harm themselves, 55.96% (155) had threatened to injure someone else, 53.07% (147) had threatened to damage or destroy property, 30.69% (85) had made threats with a weapon, and 30.69% (85) had threatened to kill someone.

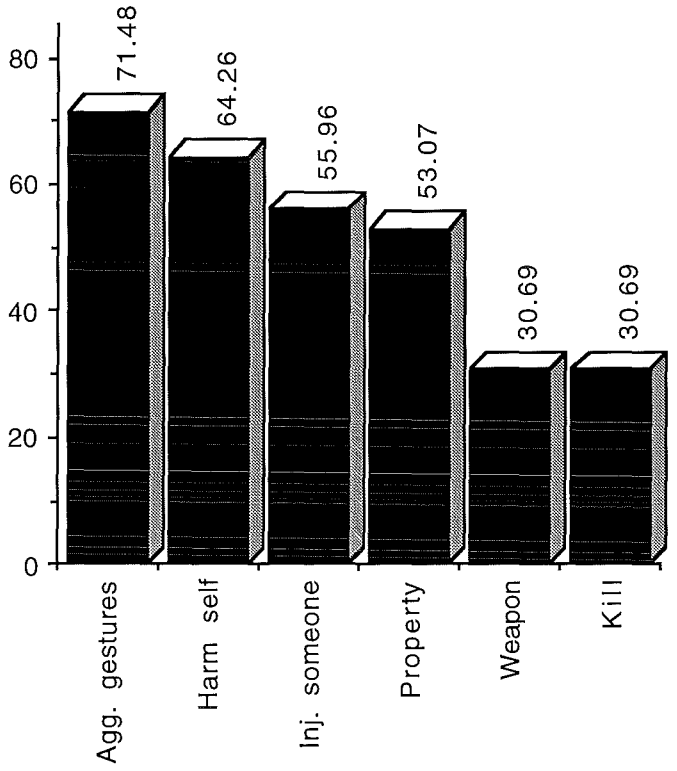

Figure 4. Threats of violence.

Respondents listed additional violent behaviours their relatives had displayed that were not included in the categories given in the questionnaire. Several of the violent sample had threatened to harm family pets.

Violence against property

In all, 65.38% (204) of the violent sample had been violent against property. Of those, 92.16% (188) had damaged property including the breaking of windows, furniture and other household effects, 47.06% (96) had defaced property, including paintings, photos and walls, and 15.69% (32) had destroyed house, buildings or personal effects by arson.

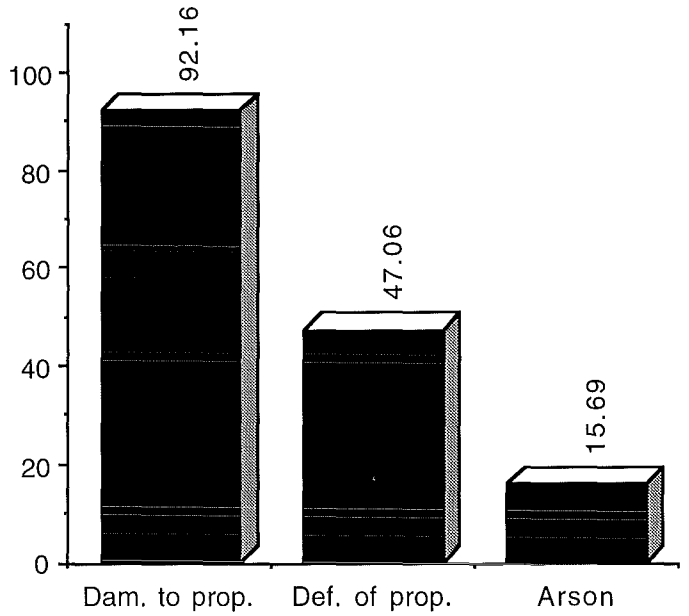

Figure 5. Violence against property.

Respondents listed additional violent behaviours their relatives had displayed that were not included in the categories given in the questionnaire. They were the theft of property, breaking and entering, and the abandonment or giving away of personal belongings. Other respondents commented that their relatives had displayed a general disrespect for property. Damage to property and possessions was not always intentional but resulted from rough use or a lack of care.

Violence against others

In all, 65.06% (203) of the violent sample had been violent against others. Of those, 88.18% (179) had committed a minor assault including punching, slapping, kicking, or grabbing someone, 33.50% (68) had committed a mild assault resulting in bruising, sprains, or welts, 13.30% (27) had committed a major assault which meant someone had been badly beaten, bones were broken, or the victim may have required hospitalization, 4.93% (10) had committed a homicide, and 3.94% (8) had committed a sexual assault.

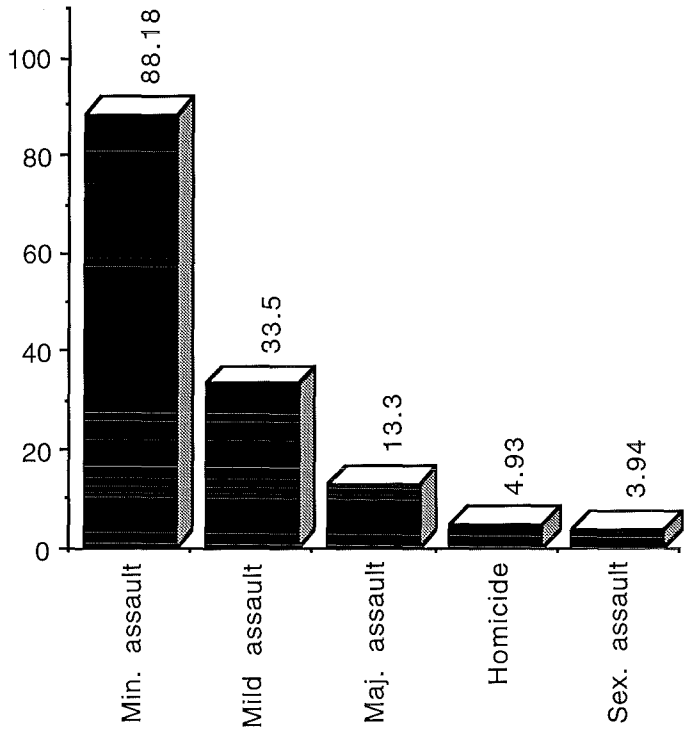

Figure 6. Violence against others.

Respondents listed additional violent behaviours their relatives had displayed that were not included in the categories given in the questionnaire. They were cruelty towards pets (dogs and cats), inappropriate sexual advances, and the dangerous driving of a motor vehicle.

Violence against self

In all, 61.22% (191) of the violent sample had been violent against themselves. Of those, 72.77% (139) had made a suicide attempt, 35.08% (67) had exhibited repetitive type behaviours such as picking and scratching at skin, pulling out hair, and hitting self repetitively, 34.55% (66) had inflicted a mild injury on themselves, such as bruises, sprains, cuts, and welts, 14.66% (28) had inflicted a major injury, and 3.66% (7) had taken their own lives.

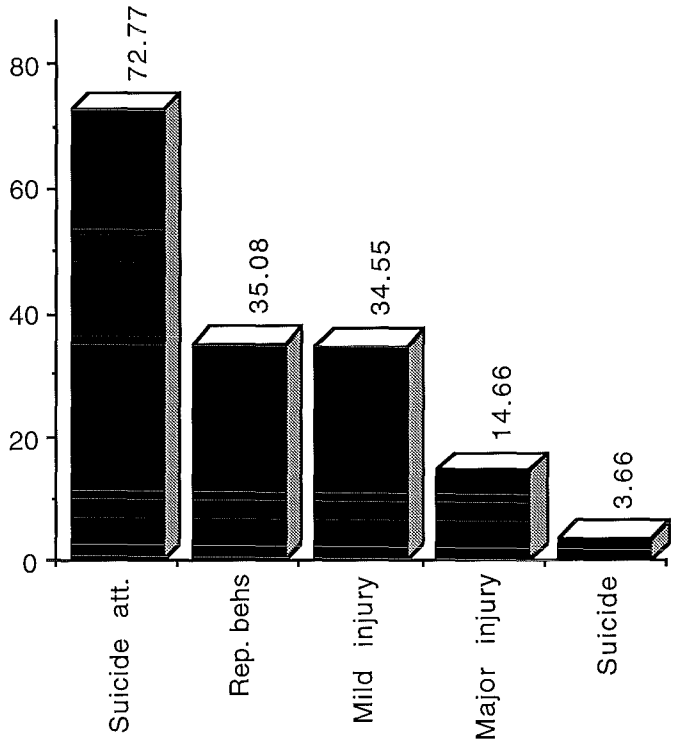

Figure 7. Violence against self.

Respondents listed additional violent behaviours their relatives had displayed that were not included in the categories given in the questionnaire. They were disfigurement by tattoos, shaving of hair and eyebrows, a general neglect of health, failing to sleep, refusing to eat or drink, a lack of adequate personal hygiene, the use of drugs and alcohol, and refusing to take prescribed medication.

Combinations of types of violence

In all, 12.5% (39) of the violent sample had exhibited 1 type[3] of violence only. This was most often a threat of violence 48.72% (19), followed by violence against others 30.77% (12), violence against self 12.82% (5), and violence against property 7.69% (3).

In all, 24.36% (76) of the violent sample had displayed 2 types of violence. Threats of violence in combinations with violence against others and violence against self 30.26% (23) were the most frequent.

In all, 33.33% (104) of the violent sample had displayed 3 types of violence and 29.81% (93) of the violent sample had displayed all 4 types of violence.

Frequency of Violence

Isolated instances of violence typically occurred at the onset of illness, often before a diagnosis had been made or the individual had been stabilized on medication. Episodic and ongoing instances of violence were frequently the result of a psychotic relapse.

Threats of violence [4]

In all, 40.76% (97) of those who had threatened violence had made episodic threats, 40.34% (96) had made isolated threats, and 18.91% (45) had made ongoing threats of violence.

Violence against property

In all, 49.44% (88) of those who had been violent against property had done so in isolated instances, 34.83% (62), had been episodic, and 15.73% (28) had displayed ongoing violence against property.

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[3] A "type" of violence refers to the four different categories of violence used to classify violence in the questionnaire; threats of violence , violence against property, violence against others, and violence against self.

[4] Some respondents listed more than one frequency for different categories of threatening behaviours. For example, one respondent's relative had made isolated threats of suicide while other categories of threats had been episodic. Each frequency was included separately.

Violence against others

In all, 49.70% (82) of those who had been violent against others had done so in isolated instances, 32.12% (53) had been episodic, and 18.18% (30) had displayed ongoing violence against others.

Violence against self

In all, 53.59% (82) of those who had been violent towards themselves had done so in isolated instances, 27.45% (42) had been episodic, and 18.95% (29) had displayed ongoing self directed violence.

Frequency of violence for all types combined

For all types of violence combined 47.41% of those who had been violent had done so in isolated instances, 34.60% had been episodic, and 17.98% had displayed ongoing behaviour.

From the extent, kind, and frequency of violence findings it was apparent that most acts of violence were not of a minor nature, as Buckley et al. (1990) suggested. There was a high percentage of people that were violent for all types of violence and the frequency with which violent behaviour occurred was also high. However, it was evident that family property was at risk as Buckley et al. (1990) found.

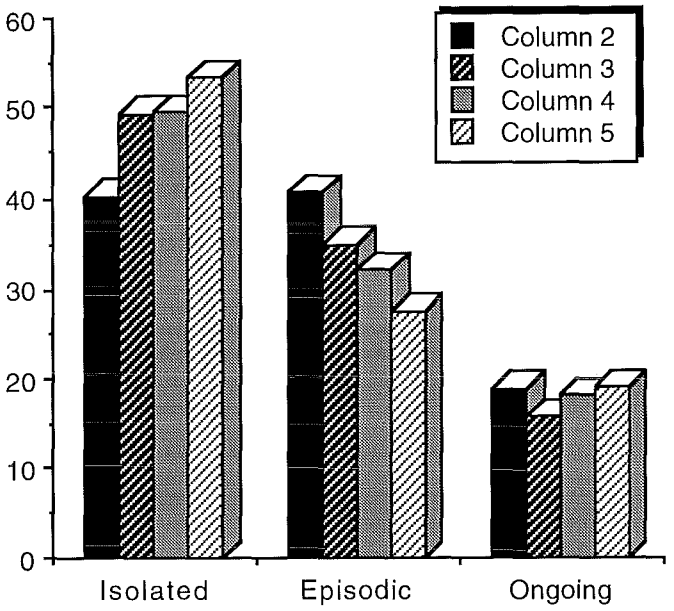

Figure 8. Frequency of violence for all types separately.

Column 2 = Threats of violence
Column 3 = Violence against property
Column 4 = Violence against others
Column 5 = Violence against self

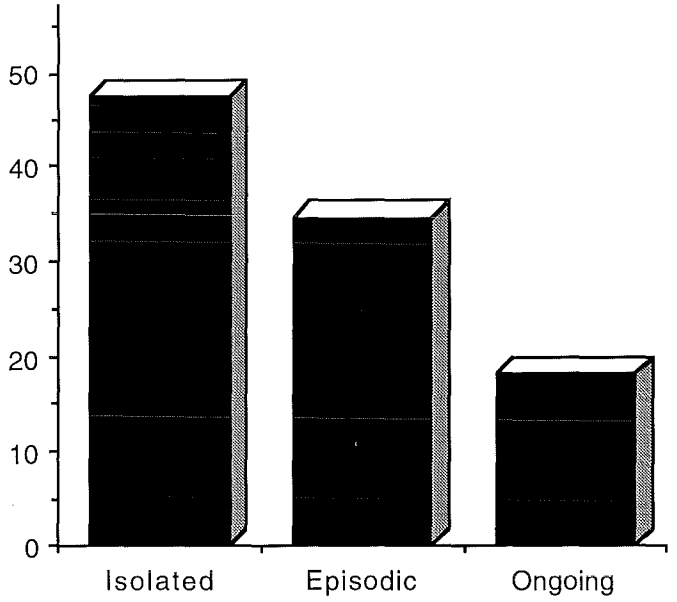

Figure 9. Frequency of violence for all types combined.

The Characteristics of those with Schizophrenia who were Violent

Age first Violent (246 responses = 78.85%)[5]

The average age for a first violent episode was 21.40 years. The majority of the violent sample, 81.30%, had a first violent episode before 25 years of age.

Sex Differences (311 responses = 99.68%)

The total sample consisted of 69.80% (289) males, and 30.19% (125) females. The violent sample (75.18% (312) of the total sample) was 69.77% (217) male and 30.23% (94) female. There was little if any difference, on face value alone, between the percentages of males and females that were violent. However, there may have been differences in the intensity and frequency of violent behaviour between the sexes. Krakowski et al. (1986), Tardiff (1984), and Tardiff and Deane (1980) found males to be generally more violent.

Comparisons with the Non-Violent

(310 responses=99.36%)

Age schizophrenia developed and was diagnosed

Schizophrenia developed in those who had been violent at 18.78 years of age on average. Those in the sample who had never been violent developed schizophrenic symptoms at 21.82 years of age on average.

Schizophrenia was diagnosed in those who were violent at 22.16 years of age on average. Those in the sample who had not been violent were diagnosed at 24.79 years of age on average.

These findings suggest that either, schizophrenic symptoms were present at an earlier age for violent individuals, or, the symptoms of schizophrenia may

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[5] This is the percentage of respondents that completed this part of the questionnaire. The results that follow are expressed as a % of the number of people that completed this part of the questionnaire.

have been more noticeable because of violent behaviour and a diagnosis followed earlier for that reason.

Length between symptoms and intervention

The length of time between the development of schizophrenic symptoms and diagnosis was 3.39 years on average for the violent sample (Males = 3.13 years, females = 3.64 years). For the non-violent sample the length of time between the development of schizophrenic symptoms and diagnosis was 2.97 years on average (Males = 3.60 years, females = 2.34 years).

There was a small difference in the length of time between symptomolgy and diagnosis between violent and non-violent individuals. Silverstone (1993) and Mullen (in press) suggest that people who have a delay of 6-12 months before treatment, after the onset of symptoms, do less well than people who start treatment much earlier.

Change in Violence with Age (217 responses = 69.55%)

In all, 58.53% (127) of respondents noticed a change in violent behaviour as their relative became older. 92.13% (117) of those noted a decrease in the amount and intensity of violent behaviour while the remainder, 7.87% (10), reported an increase in the level of violence as their relative aged.

Respondents related the improvement of condition to individual maturity on their relatives part. Those with schizophrenia were more aware of their illness, had learnt to recognize when violent behaviour might occur, and were better able to handle the situation if violence did arise. Improvements in medication and supervision were also a factor.

These results imply that younger people were generally more violent which is in accordance with the findings of Straznickas (1993), Buckley et al. (1990), Swanson et al. (1990), Swan and Lavitt (1988), Roy et al. (1987), Krakowski et al. (1986), Tardiff and Koenigsberg (1985), and Tardiff and Sweillam (1982).

When and Why Violence Occurred

State of Mind

Threats of violence [6] (257 responses = 92.78%)

In all, 54.86% (141) of the violent sample were psychotic when threats of violence were made, 17.12% (44) were stable on medication but under stress, 5.45% (14) were stable on medication, 2.72% (7) were in another state of mind not listed, and for 11.67% (30) the state of mind was not known. The rest of the violent sample, 8.17% (21), had been in different states of mind for different violent episodes.

Violence against property (186 responses = 91.18%)

In all, 60.22% (112) of the violent sample were psychotic when violent against property, 11.83% (22) were stable on medication but under stress, 4.84% (9) were stable on medication, 2.69% (5) were in another state of mind not listed, and for 12.90% (24) the state of mind was not known. The rest of the sample, 7.53% (14), had been in different states of mind for different violent episodes.

Violence against others (185 responses = 91.13%)

In all, 51.19% (95) of the violent sample were psychotic when violent against others, 16.26% (30) were stable on medication but under stress, 11.33% (21) were stable on medication, 8.87% (16) were in another state of mind not listed, and for 3% (6) the state of mind was not known. The rest of the sample, 9.35% (17), had been in different states of mind for different violent episodes.

Violence against self (172 responses = 90.05%)

In all, 52.33% (90) of the violent sample were psychotic when violent against others, 22.10% (38) were stable on medication but under stress, 8.72% (15) were stable on medication, 4.07% (7) were in another state of mind not listed, and for 3.49% (6) the state of mind was not known. The rest of the sample, 9.30%

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[6] Some respondents listed more then one state of mind for their relative when violent. Each state of mind was recorded separately.

(16), had been in different states of mind for different violent episodes.

States of mind for all types of violence

For all types of violence combined, 54.65% of the violent sample were psychotic during violent episodes, 16.83% were stable on medication but under stress, 7.59% were stable on medication, 4.59% were in another state of mind not listed, and for 7.77% the state of mind was not known. The rest of the sample, 8.59%, had been in different states of mind for different violent episodes.

From the state of mind findings it was apparent that the majority of those with schizophrenia were psychotic when violent or, to a lesser extent, under considerable stress. The connection between violent behaviour from people with schizophrenia and active psychosis has been well documented (Mullen, in press; Torrey, 1983; Planansky and Johnston, 1977; Hamilton, 1976).

Several trends emerged. The more serious the violent episode the more likely the person with schizophrenia was in a psychotic state. Further, stress was a more common state of mind for 'violence against self' than for the other types of violence.

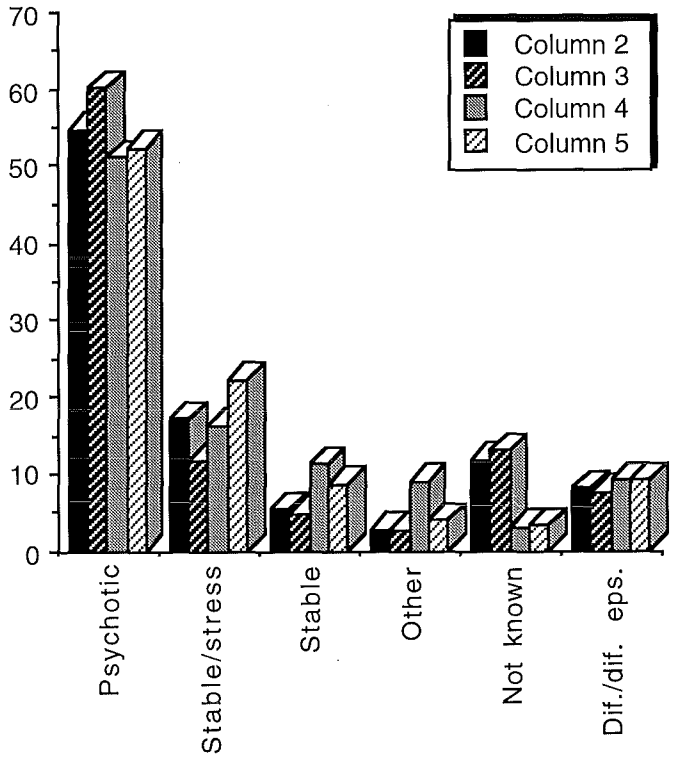

Figure 10. State of mind for all types separately.

Column 2 = Threats of violence
Column 3 = Violence against property
Column 4 = Violence against others
Column 5 = Violence against self

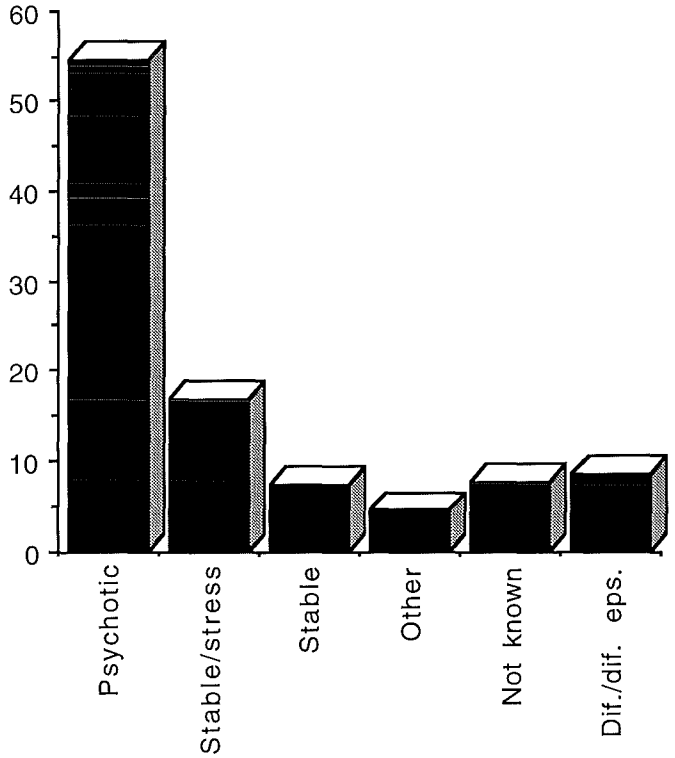

Figure 11. State of mind for all types combined.

Alcohol and Drug Use (279/275 responses = 89.42%/88.14%)

The use of alcohol contributed to violence in 13.62% (38) of the violent sample all the time and 11.83% (33) some of the time. Alcohol did not contribute to violence in 35.48% (99) of the violent sample while the question did not apply for 39.07% (109).

The use of street drugs contributed to violence in 13.09% (36) of the violent sample all the time and 5.82% (16) some of the time. Alcohol did not contribute to violence in 15.27% (42) of the violent sample while the question did not apply for 65.82% (181).

These findings were in accordance with research by Feinstein and Plutchik (1990), Swan and Lavitt (1988), Blomhoff et al. (1990), in which alcohol and/or the use of street drugs increased violence in psychiatric inpatients. Also, Torrey (1983) noted that many attacks of violence occurred in those who were using alcohol and/or drugs at the time.

Compliance with Medication (306 responses = 98.08%)

The taking of medication represented a problem. Many respondents stated that their relative was only violent when unmedicated in accordance with Swan and Lavitt (1988) and Torrey (1983) who related non-compliance with medication to an increase in violence. While 92.81% (284) of the total sample received anti-psychotic medication only 69.72% (198) complied consistently with their prescribed medication routine, 24.65% (70) complied sometimes, and 5.63% (16) never complied.

Such non-compliance often came from the dislike of the drugs side effects including lethargy and drowsiness. Swan and Lavitt (1988) also note that those who take anti-psychotics often dislike the drugs side-effects. Also, people with schizophrenia sometimes lacked insight into their condition and did not take medication because they thought they were not ill or no longer ill.

The administration of oral medication was hard to police as it needs to be taken daily. Most of the sample 40.29% (112) received it this way, as opposed to a supervised injection (usually fortnightly) 30.58% (85), and 29.14% (81) who had received both types.

Family Contact (227 responses = 72.76%)

For 32.60% (74) of respondents, the amount of contact they had with their relative affected their relative's violent behaviour. For 67.40% (153) of respondents the amount of contact they had did not affect their relative's violent behaviour.

(58 responses = 25.55%)

For 70.69% (41) of respondents, the amount of contact they had with relatives made violent situations worse. Many respondents reported that stressful contact could accelerate violent outbursts. Stress often resulted when day-to-day living became too much and violence erupted out of sheer frustration. The delegation of household responsibilities also created friction between family members and the relative with schizophrenia. Some people with schizophrenia became frustrated when they compared themselves to other, more successful, family members.

An improvement was sometimes noted when relatives left for independent circumstances. Although, this was not always possible due to the level of care those with schizophrenia often required.

Situated in middle ground 20.69% (12) of respondents had learnt a balance between too little and too much contact. They tended to avoid a situation if they thought their relative was likely to be violent.

For 8.62% (5) of respondents, increased amounts of contact with relatives lessened violent behaviour. Contact was necessary at times to support their

relative and offer them reassurance.

Pattern of Violence (220 responses = 70.51%)

In all, 55.91% (123) of respondents recognized a pattern to their relatives violent behaviour while the remainder, 44.09% (97), did not. In describing the pattern of violence many respondents recognized that violence often followed psychotic symptoms. They could tell when their relative was becoming unwell and potentially violent because they were either delusional, depressed, obsessional, or their medication was not working properly.

Patterns preceding violent behaviour are categorized into clusters of related behaviours and then ranked in order of the most to the least number of responses. All behaviours are expressed as percentages of the number of respondents that completed this part of the questionnaire.

Table 1.
Patterns preceding violent behaviour. (113 responses = 36.28%)

- Appearance of psychosis hallucinations, delusions, paranoia, obsessiveness, hyper-activity, medication not working	32.74%	(37)
- Flare ups frustration, anger, arguments, agitation	17.70%	(20)
- Stress	13.27%	(15)
- Problems with authority when requested to do something, when denied requests	10.62%	(12)
- Drug and alcohol use	7.08%	(8)
- Depression over failure, bleak outlook, low self-esteem, build up of feelings	6.19%	(7)
- Menstruation PMS and associated difficulties	3.54%	(4)
- Neglecting health refuses food, does not take medication	2.65%	(3)
- Relationship problems	1.77%	(2)
- Inadequate care	1.77%	(2)
- Blames someone for the illness	0.88%	(1)
- Provocation	0.88%	(1)
- Build up over time	0.88%	(1)

Who the Violence was Directed at

Family or Non-Family

Minor assault

For minor assaults, 63.37% of the violent sample were against family members, 16.28% were against non-family, and 20.35% had been against family and non-family.

Mild assault

For mild assaults, 62.50% of the violent sample were violent towards family members, 18.75% were violent against non-family, and 18.75% had been violent towards family and non-family.

Major assault

For major assaults, 50.00% of the violent sample were violent towards family members, 33.33% were violent against non-family, and 16.67% had been violent towards family and non-family.

Sexual assault

For sexual assaults, there were no family victims reported. 83.33% of the violent sample were violent against non-family members and 16.67% had been violent towards family and non-family.

Homicide

For homicide, 62.50% of the violent sample were violent towards family members and 37.50% had been violent towards non-family.

Family non-family distinction for all types of violence

Data for all types of violence were not combined due to the small number of homicide and sexual assault responses. Combining these data would not be an accurate representation of the family, non-family distinction.

From the results, family members were more likely then non-family to suffer

the consequences of violent behaviour from a relative with schizophrenia. In accordance with Straznickas (1993), Tardiff and Koenigsberg (1985), Mullen (1984), and Tardiff (1984) family members were about half the victims of violence. Also, violence was generally directed at those in the caregiving role who were particularly available or vulnerable, mainly parents and spouses.

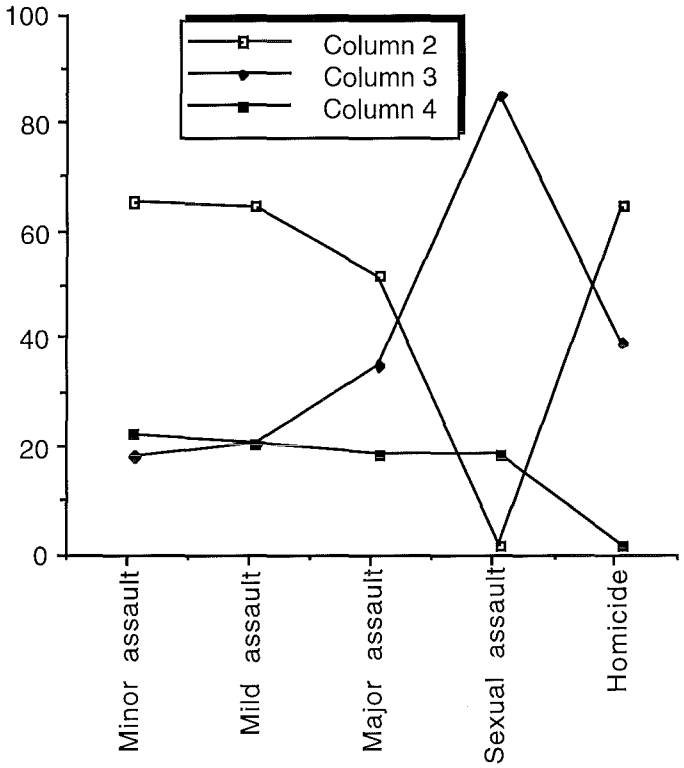

Figure 12. Violence directed at family or non-family.

Column 2 = Family
Column 3 = Non-family
Column 4 = Family and non-family

Violence Directed at One Person (251 responses = 80.45%)

In all, 58.57% (147) of the violent sample directed their violence at one person in particular, 41.43% (104) did not. As mentioned violence was generally directed at those in the caregiving role or those who had the most contact with their relatives. Parents and spouses were particularly vulnerable; especially mothers who were targets of violence for 33.33% (49) of the violent sample. Fathers were targets for 19.73% (29) of the violent sample, a parent (sex not specified) 12.24% (18), spouses 10.20% (15), self 8.16% (12), siblings 2.04% (3), and children 0.68% (1). The remainder of the violent sample directed violence at people in the greater family or at those outside of the family. The majority of violent acts were directed at close female relatives as Buckley et al. (1990) suggested.

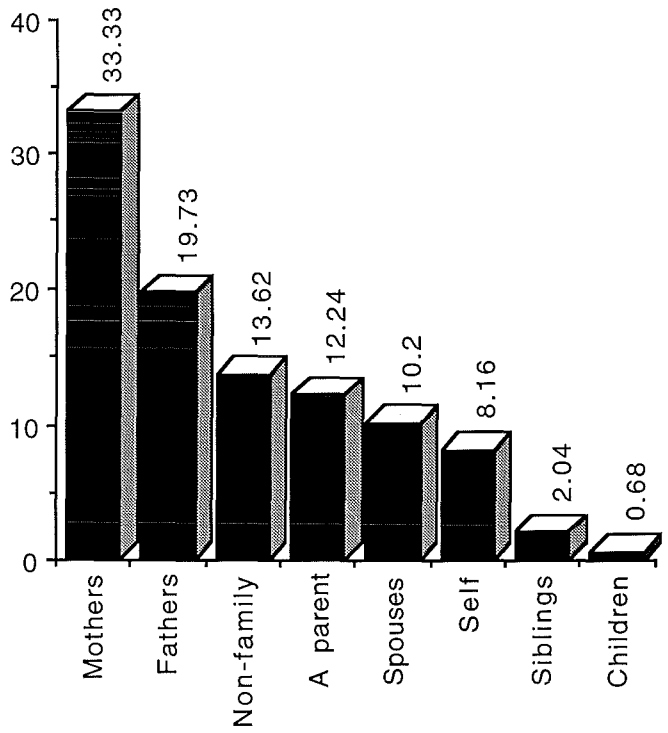

Figure 13. Violence directed at one person.

The Effects of Violence on Families

(225 responses = 72.12%)

The effects on families from violent relatives with schizophrenia were vast. Violence was not the only hardship experienced by respondents as a result of their relatives schizophrenia but a major contributor to financial burden, health problems, emotional difficulties, and relationships within and outside the family.

Financial Burden

In all, 32.89% (74) of respondents had experienced a considerable financial burden as a result of their relatives violent behaviour, including repairing damage, replacing items either destroyed or discarded, and paying court fines. Many respondents also felt a financial burden resulting from their relatives mental illness in terms of providing food, housing and constant care. These difficulties were especially hard felt by pensioners.

Health Problems

In accordance with Fadden et al. (1987), coping with relative's behaviour frequently resulted in adverse effects on the health of family members both physically and psychologically. In all, 19.11% (43) of respondents had experienced health problems. Some health problems were the direct result of violence as in the personal injury suffered in a physical attack. However, the majority of health problems were psycho-somatic. That is, physical symptoms of disease resulting from the accompanying stress. Problems that required medical intervention included, heart conditions (angina, hypertension, high blood pressure, and heart attack), ulcers, migraines, anxiety, depression, premature ageing, and epilepsy.

Psychological Problems

In all, 79.11% (178) of respondents had experienced emotional trauma and

stress as a family unit or individually. Personality and self esteem had been affected by respondents relatives' humiliating, degrading, embarrassing, and frustrating behaviour. One respondent termed it "soul destroying abuse." The unpredictability of not knowing what was going to happen next, the continual vigil over their relatives' actions, and fear of the consequences of such actions created constant worry as Hatfield (1987b), Mullen (1991), and Rollin (1980) had suggested. This often led to nightmares, insomnia, and many of the health problems already discussed. Even though respondents had a continual testing of patience and nerves many felt guilt, sorrow, sadness, permanent grief, and a sense of pity for their mentally ill relative. This ambivalence felt by family members towards their relatives was also noted by Torrey (1983).

Blame for the condition (287 responses = 91.99%)

In all, 30.31% (87) of respondents reported that their relative blamed them for their mental illness, 3.48% (10) laid the blame sometimes, 3.48% (10) had blamed them in the past, while 62.72% (180) had never blamed the family for their illness. Blame from an ill relative increased the guilt many respondents already harboured concerning their relatives condition.

Intimidated by Relatives' Actions (280 responses = 89.74%)

In all, 71.07% (199) of respondents reported they had felt intimidated by their relatives' actions while 28.93% (81) of respondents had not. Such intimidation increased the fear and apprehension that many respondents already felt towards their relatives.

Family Relationships

Relationships between family members, friends and neighbours, had been affected for 31.56% (71) of respondents. Some felt the closeness of the family had been lost through internal difficulties that disintegrated and fragmented the family bond. Stress had led to marriage problems, divorce, and permanent rifts between immediate and distant family members. In some cases siblings

had shifted overseas because of the resentment they felt towards their ill relative who they thought had received the majority of parental attention.

A general loss of contact with friends sometimes occurred. For example, some people seldom entertained because of an ill family member's violent behaviour.

Many respondents felt alienated by friends, neighbours and the community because ignorance and a general lack of understanding surrounded the condition. Often, allowances had not been made for a mentally ill relatives and people inside and outside of the family were unforgiving of past behaviour.

In accordance with Swan and Lavitt (1988) domestic violence has a potentially devastating effect on families who must often live in tense and fearful environments.

How Families Coped with Violence

Most families utilized a variety of different techniques to cope with violent behaviour. However, coping implies a handling of a situation and from the results it was clear that respondent's behaviour was often a reaction to violence rather than any thought out coping strategy.

A progression in the way people handled violence was evident. Respondents had learnt to diffuse situations after initially confronting them. This meant a transformation from initially confrontational reactions more interactive behaviours.

Some strategies used for coping with violence were specific to certain types of violence. For example, with violence against others respondents sometimes fought back. However, for violence against self, respondents were more likely to physically restrain their relative. For this reason the different strategies used for different types of violence are included in separate tables.

Coping behaviours are categorized into clusters of related behaviours then ranked in order of the most to the least number of responses. All behaviours are expressed as percentages of the number of respondents that completed this part of the questionnaire. Many respondents adopted more than one coping strategy. All strategies that respondents used are included separately.

Threats of Violence

Table 2.

Coping strategies for threats of violence.

- Enlisted help of others				
police, physical removal to hospital	26.83%	(44)		
hospital, mental health team, crisis team, domicilary nurse, doctor, Psychiatrist, social worker, Schizophrenia Fellowship fieldworker, minister	42.07%	(69)		
friend, neighbour	3.66%	(6)		
			72.56%	(119)
- Talked with diffused situation, avoided confrontation, reasoned calmly, supported, loved, distracted,			37.20%	(61)
- Retreated backed off, retreated to a safe area until calmed down to protect own safety			33.54%	(55)
- Ignored			17.68%	(29)
- Tough love set rules and guidelines for conduct, restricted certain activities, stood firm, did not put up with certain behaviours asked relative to leave			8.54%	(14)
- Argued			5.49%	(9)
- Confronted			5.49%	(9)
- Fought back physical confrontation			4.27%	(7)
- Threatened with action hospital, police			3.66%	(6)
- Persuaded to take medication			2.44%	(4)
- Prayed			2.44%	(4)
- Used the law issued trespass notice			2.44%	(4)
- Removed dangerous objects knives, pills			1.83%	(3)
- Ignored but watched kept watchful eye so no harm would come to him/her			1.22%	(2)
- Improved education and personal knowledge			1.22%	(2)
- Cried			0.61%	(1)
- Nothing worked			0.61%	(1)

Violence Against Property

Table 3.
Coping strategies for violence against property.

- Enlisted help of others	3.26%	(3)		
police, physical removal to hospital	19.95%	(19)		
hospital, doctor, therapist, psychiatric nurse	27.29%	(26)		
friend, neighbour	1.05%	(1)		
			51.55%	(49)
- Talked with calmed down, avoided confrontation, diffused			19.95%	(19)
- Retreated backed off, retreated to a safe area until calmed down to protect own safety			19.95%	(19)
- Punished paid for repairs, worked it off			14.81%	(14)
- Nothing worked no strategy used, could not cope			10.50%	(10)
- Ignored			9.45%	(9)
- Stressed that the behaviour was unacceptable			7.35%	(7)
- Confronted			6.30%	(6)
- Fought back physically / forcibly restrained			3.26%	(3)
- Persuaded to take medication			3.26%	(3)
- Did not replace or repair damaged items			2.10%	(2)
- Improved education and personal knowledge			2.10%	(2)
- Used the law issued trespass notice			2.10%	(2)
- Argued anger expressed			1.05%	(1)
- Cried			1.05%	(1)

Violence Against Others

Table 4.
Coping strategies for violence against others.

- Enlisted help of others				
police, physical removal to hospital	30.00%	(21)		
hospital, after hours team, crisis team, domicilary nurse, doctor, Schizophrenia Fellowship fieldworker	35.71%	(25)		
friend, neighbour	5.71%	(4)		
			71.42%	(50)
- Retreated				
backed off, retreated to safe area until calmed down to protect own safety,			25.72%	(18)
- Talked with				
avoided confrontation, diffused situation, reasoned calmly, supported, distracted,			21.43%	(15)
- Fought back				
physical confrontation, defended self			15.71%	(11)
- Argued			8.57%	(6)
- Ignored			7.14%	(5)
- Confronted			7.14%	(5)
- Tough love				
set rules and guidelines for conduct, ask relative to leave household banned from household			5.72%	(4)
- Used the law				
issued trespass notice			4.29%	(3)
- Met their demands				
revolved household around them			2.86%	(2)
- Nothing worked			2.86%	(2)
- Threatened with action				
police			2.86%	(2)
- Persuaded to take medication			1.43%	(1)
- Improved education and personal knowledge			1.43%	(1)
- Removed dangerous objects				
potential weapons, knives			1.43%	(1)

Violence Against Self

Table 5.
Coping strategies for violence against self.

- Enlisted help of others	3.66%	(3)		
police, physical removal to hospital	15.85%	(13)		
hospital, community treatment team, crisis team, domicilary nurse, doctor, psychiatrist, visiting district nurse	58.54%	(48)		
friend, neighbour	6.10%	(5)		
			84.15%	(69)
- Talked with reasoned calmly			34.15%	(28)
- Ignored			7.32%	(6)
- Restrained and intervened			7.32%	(6)
- Observed closely			4.88%	(4)
- Removed dangerous objects knives, pills			4.88%	(4)
- Confronted			3.66%	(3)
- Persuaded to take medication			3.66%	(3)
- Improved education and personal knowledge			2.44%	(2)
- Nothing worked could not cope			2.44%	(2)
- Retreated			2.44%	(2)
- Used the law had committed			1.22%	(1)

Most Disturbing and Difficult Type of Violence to Deal With (200 responses = 64.10%)

The results appear consistent with Malone (1991) in that public violence at the time of committal was easier to live with than the hidden internal aggression that the family had to cope with day to day.

The most disturbing and difficult type of violence to deal with depended on the type of violence respondents had experienced. This was why homicide was not the most disturbing type of violence for every respondent.

Types of violence are categorized into clusters of related behaviours then ranked in order of the most to the least number of responses. All behaviours are expressed as percentages of the number of respondents that completed this part of the questionnaire.

Table 6.
Most disturbing and difficult type of violence.

- Verbal violence abusive, foul, degrading, demeaning language yelling and shouting of abuse	21.00%	(42)
- Threats	20.00%	(40)
- Physical assault / attack	14.50%	(29)
- Violence against self	14.00%	(28)
- Unpredictable violence characterized by sudden outbursts, unprovoked and unexpected	10.00%	(20)
- Violence against property	7.50%	(15)
- All / any any or all of the violence that their relative exhibited	4.50%	(9)
- Violence involving others people outside the family, police, neighbours	3.50%	(7)
- Alcohol related violence	2.50%	(5)
- Homicide	1.50%	(3)
- Violence within the family	1.00%	(2)

Satisfactory Community Care (277 responses = 88.78%)

In all, 60.65% (168) of respondents reported that their relative received satisfactory community care or that the standard of care was adequate. Several comments were made that satisfactory care was available after some time and perseverance. Conversely, 35.02% (97) of respondents reported that their relative did not receive satisfactory care. A further 1.81% (5) reported that their relative refused to accept any community care or had not sought any. The remainder, 1.44% (4), responded that community care was available to varying degrees or that their relative required more than was available. This question was not applicable for 1.08% (3) of respondents as their relative was institutionalized.

Additional Information

Section nine of the questionnaire served as a general comments section. Respondents listed areas of concern, asked relevant questions, and provided directions they wished future research to go. Some of the information related to the effects of violence on families and was incorporated into that section. Many respondents also included information about their relative in a case history fashion, providing an invaluable insight into everyday life.

Much positive feedback was received. Respondents were generally grateful for the work being done, the interest shown, and having the opportunity to share their experiences.

DISCUSSION

The results are summarized. The meaning and implication of findings are discussed. Methodological considerations of the study then follow. The need for research is addressed and directions for future research are outlined. Finally, concluding comments are made.

Results Summary

Extent Kind and Frequency of Violence

Three quarters of respondents to the questionnaire had experienced violence from a relative with schizophrenia. Violence was most often expressed in the form of threats or threatening-type behaviour which occurred in isolated instances, typically at the onset of the illness. Other types of violent behaviour, such as violence against property, persons, and self, were also relatively frequent.

The Characteristics of Those who were Violent

There was no sex difference between the percentage of people that had been violent and those that had not. The symptoms of schizophrenia were manifested earlier and diagnosed earlier in those who had been violent compared to those who had never exhibited violent behaviour. The majority of people were first violent before 25 years of age. Respondents mostly noted an improvement of schizophrenia-related violence with age, due to maturity, better medication, care and understanding.

When and Why Violence Occurred

Over half of the sample were violent when psychotic. The use of alcohol and/or drugs contributed to violence for some, but non-compliance with medication was a more widespread factor. One third of respondents reported

that the amount of contact they had with relatives contributed to the violent behaviour in some way. Violence sometimes erupted when day-to-day living became stressful.

Who the Violence was Directed at

Family members were victims of physical violence more often than people outside of the family. Those in the caregiving role, parents and spouses, were particularly vulnerable.

The Effects of Violence on Families

Families were affected financially, physically, and mentally by a relatives violent behaviour. Relationships with people inside and outside of the family were also affected.

How Families Coped with Violence

Families used a variety of strategies to cope with violence. Most often they enlisted the help others, tried to diffuse the situation, or retreated to safety.

Implications of the Results

Violence Identified as a Problem for Families

That schizophrenia and violence is a very real issue is evidenced in part by the responses to the questionnaire. Respondents offered information about an often painful period of their lives, that was past for some and ongoing for others. This was encouraging because there exists a need for many to hide this from any possible source of revelation (Leggat & Carey, 1987). The number of people that responded to the questionnaire was also encouraging. Shaughnessy and Zechmeister (1985) suggest that a response rate of 30% is average for postal questionnaires. The response rate to this questionnaire was 42%.

That schizophrenia and violence is a very real issue is also evidenced by the findings for the frequency and extent of violent behaviour. They indicate that violence, from a relative with schizophrenia, is a re-occurring problem for many families.

Not all families are at risk and not all people with schizophrenia are violent. However, when people with schizophrenia do become violent, family members are more likely to suffer the consequences of such behaviour than members of the general public.

The violence families experience can create financial, health and emotional problems. Many have had to develop their own strategies for coping out of necessity; often as a reaction to extremely stressful and dangerous situations.

Families are faced with a dilemma in caring for a violent relative. Most often they want to provide the care and support that their relative needs. From the results it was evident that this very contact can provoke violent behaviour and certainly puts family members in the firing line if violence was to occur.

The large number of questionnaires completed by mothers reflected the fact that it is on them that the major responsibility of care is thrust. This is not surprising as Seeman and Hauser (1985) found that men with schizophrenia most often lived with their mothers.

The symptoms of schizophrenia are most unpleasant for the sufferer but he or she is often shielded, by the nature of the illness itself, from the full realization of what has become of him or her. Families have no such protection and are often ill-equipped financially and emotionally to cope.

Early Intervention and Maintenance of Care

The results indicate that there was often a significant delay from the time symptoms of schizophrenia first appeared until appropriate medical

intervention was available. This point emphasises the need for adequate initial assessment and early intervention in the treatment of schizophrenia.

Violence most often occurred in a psychotic state. It was apparent from the findings that psychosis, in the form of delusional belief patterns and alike, was fuelled by several factors. The use of street drugs and/or alcohol figured in the results, but non-compliance with medication was the most prolific problem. Many respondents stated that their relative was only violent when unmedicated and that violence often ceased once the sufferer had been stabilized on medication. This point stresses the importance of maintenance of medication and care once a diagnosis has been made.

Hafner and Boker (1982 (Cited in Mullen, in press)) concluded that those with schizophrenia who commit acts of violence nearly always have the disorder for some time. Serious offending is rare in the first illness and seems to be more likely to arise in those who have been ill for years rather than weeks. A lack of maintenance of care is again implicated in the etiology of violent behaviour for those with schizophrenia.

Governmental Policy

There is no coherent plan for mental health in New Zealand (O'Hare, 1994). So far the Government has failed to provide adequate facilities, funding, and policy to meet consumer needs and have distanced themselves from the responsibility of funding support services. Yet, government policies of deinstitutionalization and health reform may only benefit people with mental illness if good community support and care are provided.

Hospital treatment as well as satisfactory community care are not always forthcoming and can be notoriously hard to obtain. Results indicate that one third of the total sample did not receive satisfactory community care. An Auckland survey found, in an Audit Office report on community care for

people with mental illness, inadequate resources in health services available (O'Hare, 1994).

A reverse of the trend towards community care without the provision of adequate support and medical back-up for the mentally ill is what is needed. Devenson (1992) suggests that community care is a better option for the mentally ill and their families, providing the standard is adequate. It is dangerous to force community care onto a society which is ill equipped to cope.

Families need help and support in coping with violence and living with its effects. It would seem that practically all the social support that does exist for families is provided by voluntary, non-profit organizations such as the Schizophrenia Fellowship.

Existing health policy treats people with mental illness as being able to behave logically, but when these people are unwell the illness can preclude logical actions on behaviour. For example, the Mental Health Act (1/Nov,1992) effectively stifles detailed examination of how patients who claim they are fit and well can be discharged from psychiatric institutions.

The confidentiality rights of the mentally ill are intolerable and cause their families much anguish. O'Hare (1994) states, that over scrupulous concern with patient confidentiality has had the effect of excluding caregivers from a full role in the patients recovery. Any information concerning a patient is confidential, even details on the medication they are taking and when it should be taken are not available to families.

Furthermore, people must come for treatment voluntarily. If they refuse, the family can do nothing except charge their relative with an offence and force a compulsory treatment order through the courts. This type of system often permanently damages the relationship between the family and relative they have had to force into care.

Families Should be Listened to

Families should be listened to and believed as part of the process for making an accurate assessment. In describing the pattern of violence many respondents recognized that violence often followed psychotic symptoms. Family members had little difficulty in assessing when a relative was becoming unwell and potentially violent because they were delusional, depressed, obsessional, or their medication was not working. Respondents could also recognize how the amount of contact they had with ill relatives affected violent behaviour.

However, historically the attitudes of the helping professions have left families in very difficult situations. Families may receive little empathy and support from therapists who are liable to censure and distrust them (Warner, 1985).

Psychiatrists' assessments need improvement. What Devenson (1992) learnt repeatedly was the immense gap between the professional's view of the illness and what families knew. Unwell relatives may be assessed as stable enough to live in the community when families know they are not.

The psychiatrist's main concern is with the patient. In the interests of the patient, psychiatrists are often reluctant to tell the family the diagnosis or likely outcome. They may even add to the family's guilt by cushioning blame for the condition. To make matters worse, many people with schizophrenia are able to put on a rational front when confronted by authority figures. They routinely act more ineptly and abusive towards their family.

The family cannot win. If help is sought for disturbed relatives the medical profession may report that they are being over-protective and that unsatisfactory family relationships are to blame. If they close the door on their son or daughter they are accused of neglect and may risk his/her suicide. The results indicate that their ill relative may blame them for the illness which

may also add to their sense of guilt.

Education and Understanding

Not all people with schizophrenia are violent. However, the public cannot be expected to understand the relationship between schizophrenia and violence without accurate and frank information which can only result from straightforward and honest research and reporting. Facts must be stated without sensationalising or misinterpreting them.

Accounts of violence by people with schizophrenia appear regularly in newspapers. Not all are sensationalized, some are factual court reports. Nothing is gained by claiming that such incidents do not occur or only occur rarely because there are simply too many. The opportunities that the media provide should be used to increase public awareness and understanding about schizophrenia.

Research is essential to alleviate misconceptions and increase public understanding of mental illness, decrease the communication gap between families and professionals, notify statutory authorities to tailor the Mental Health Act to suit families, and in general to alleviate conflict between families and the establishment.

A better understanding of how violence affects families is required to determine caregivers needs and indicate where services are lacking. Hopefully, methods of avoidance and prevention can be worked out and coping skills developed.

It is noticeable, in spite of current research, the significant number of people who feel blame either for causing the illness initially or subsequent relapses. They also carry the burden of living with someone whose actions can be unpredictable and distressing and whose emotional responses are unrewarding.

The Schizophrenia Fellowship has found a general lack of understanding and knowledge concerning schizophrenia exhibited by the medical profession, schools, universities, employment services, the Justice Department, etc. The least helpful are those who lack knowledge of mental illness but hold positions of authority.

Monahan (1992) suggests that the beliefs that mental disorder is linked to violent behaviour are important for two reasons. Firstly, such beliefs drive formal laws and policies by which society attempts to control the behaviour of disordered people and regulate the provision of mental health care. Secondly, and more importantly they determine our informal responses and modes of interacting with individuals who are perceived to be mentally ill.)

Negative Feedback

Several criticisms were levelled at the questionnaire. Some respondents were concerned at providing information that could be used to justify locking people away. Others respondents were worried that increased attention given to schizophrenia and violence would add to the stigmatization that already make the mentally ill a persecuted minority.

This type of negative or concerned response is an indication that people are very afraid of violence being publicly discussed as a real symptom of schizophrenia. It is also understandable. The shame and guilt surrounding schizophrenia as well as stigma of mental illness are bad enough but the threat of loved ones being locked up is also very real. However, we do have to accept that violence whether spoken, threatened, or acted out is a real symptom of schizophrenia and probably the worst and most difficult to deal with aspect of schizophrenia.

Violence may be result from poor medication and follow up care, but it does exist. To pretend that it does not is in itself dangerous. Yet, violence as a

symptom has been glossed over and minimized in the past. We are denying the reality of the mentally ill and violence primarily because we want to protect the non-violent mentally ill from continued stigmatization. At the same time we are constraining the rights of the mentally ill who are violent to any possible cure, understanding, or respite from their condition.

Methodological Considerations

Questionnaire Design

Behaviour categories did not always pick up the exact detail of individual violent episodes. For example, some behaviour categories occurred concurrently as in the threat to kill with a weapon which is a threat to kill as well as a threat with a weapon. These behaviours had to be included as separate incidents and subsequently some detail may have been lost. However, categories generally covered all types of violence as few respondents included additional behaviours to those that were already listed.

Some respondents were confused as to the meaning of the frequencies they had to select from because definitions for the frequency of violent behaviour were not given. The following definitions should have been included; Isolated = few instances in the past; Episodic = re-occurring, flares up from time to time; Ongoing = consistently or regularly.

How successful the coping strategies that people adopted were could not be gauged. With the inclusion of a likert type scale it would have been possible for respondents to rate how effective a particular coping strategy was. This may have been of some benefit in suggesting future strategies for people to adopt.

Not all questionnaires were returned completely filled out. This suggests that the questionnaire may have been too long or required to much detail. Also, as mentioned, some aspects of the questionnaire may have provided some

confusion and could have been improved upon. However, most respondents generally completed the questionnaire in the intended manner and even questionnaires that were returned incomplete or sketchy still helped compile much invaluable information. Some respondents may not have returned questionnaires if they thought they had to be completely filled out.

The Definition of Violence

Verbal violence should have been included in the study as a violence type. Kay et al. (1988a) found verbal violence the most common form of violence in a study of psychiatric in-patients. Respondents found this sort of behaviour the most disturbing and difficult to deal with. Also, 14 respondents had relatives who were not violent in any other way than verbally but because the behaviour did not fit the definition of violence given they could not be included in the violent sample. Verbal abuse or verbal violence as some respondents noted included the expression of violent thoughts against others and self such as obscene and degrading language, verbal bullying and emotional blackmail, anger, contemplation of violence, talk and thoughts of suicide, yelling and shouting, and argumentative behaviour.

Subjective Interpretation

The descriptive details of violence and estimates of the frequency of violent behaviour among individuals should be interpreted within the methodological constraints of a retrospective analysis. For example, there are problems associated with the recall of information, especially considering the time span involved over the course of such an illness. Respondents may report information sincerely yet, time has clouded their objective judgement. Some respondents may also have had greater hindsight or recognized abnormal behaviour while others did not. Others may have become desensitized to abnormal behaviour.

Some difficulty was evident in assessing such concepts as the state of mind of a violent relative. On average, 10% of respondents could not recognize their relatives state of mind. However, it is not possible to remove the caregivers' judgement from what constitutes violent behaviour or the frequency of violent behaviour and receive solely objective information.

As mentioned, findings from the study tell us little about this phenomena as it occurs among people not already labelled by the mental health service the criminal justice system, or both. This shortcoming could only be avoided by focusing on assessment of community residents randomly selected. However, such an approach would be impractical. The use of hospital data bases and records would also provide a potential researcher with certain ethical dilemmas and restraints.

Schizophrenia Research

One percent of all people suffer directly from schizophrenia at some time in their lives while many more are indirectly affected. It takes up more hospital beds than any other single illness and is a more destructive disease to society than Aids, because more people have the condition and its economic impact is much greater (Devenson, 1992). Silverstone (1993) estimated the cost of schizophrenia to the New Zealand economy was $500 million per year. Yet, there is little research into schizophrenia. Ten times more per patient is spent researching heart disease while over fifty times more per patient is spent on cancer research (Devenson, 1992).

Any further research examining schizophrenia and violence needs to address the methodological issues already outlined by employing a wider definition of violence to include verbal violence, including in-depth interviews to capture the nuances of behaviour that standard questionnaires do not, and adopting wider sampling techniques.

There was a general concern expressed by many respondents about violence committed against the mentally ill. Some respondents felt their relatives were more often the victims of assaults rather than the perpetrators of such attacks. They were frequently manipulated by some members of society including others with the disorder because they were especially vulnerable or 'easy targets' as one respondent noted. Torrey (1983) suggested that for every mentally ill person that committed a crime at least 10 or even 100 were victims. Swanson et al. (1990) estimated that there was more chance of being assaulted by an alcoholic than someone with schizophrenia.

The triggers of violent behaviour could be studied by examining closely the events preceding violence. Certain states, anger, hatred, and verbal abuse, may be forerunners to violence. This was achieved in part by examining the state of mind of people at the time of violent behaviour and respondents reporting patterns preceding violent behaviour. Straznickas (1993) found accounts of violent incidents contained several situational factors including limit setting, paranoid delusions, and substance abuse, that immediately preceded assaultive behaviour. Rollin (1980) discovered that relatives could sometimes trace back the reason for violence to a recent frustration the person had suffered. Although, at other times the violence occurred unpredictably.

Maori, European, and other ethnic and culturally different groups with schizophrenia may be affected or act in different ways. Lawson et al. (1984), in a study of psychiatric inpatients, found black subjects were significantly less violent. White patients made more violent threats, committed more violent acts against self, and were more likely to be secluded or restrained. The same racial differences were seen when those with schizophrenia alone were considered.

It is recognized that schizophrenia affects males and females differently. In research by Straznickas (1993), males were more likely to assault non-family

members than females but equally likely as females to assault family members. In addressing gender issues it may be that the treatment of violent behaviour needs to be considered, differently for males and females.

The risk of suicide and its prevention could be examined more closely. Tardiff and Sweillman (1982) found assaultive people more likely to be suicidal than non-assaultive people. Torrey (1983) noted that when suicide occurred in acute psychosis it was usually accidental. However, suicide did not usually occur during psychosis and was most often planned. Bernheim (1982) found delusional ideas, despair, and impulsivety all contribute to a high risk of suicide and that depression represented the single most important cause of suicide among persons with schizophrenia, just as it does among persons without schizophrenia. Those at highest risk have a remitting and relapsing course, good insight into their condition, poor response to medication, and are socially isolated.

In examining criminal related violence and schizophrenia it may be possible to study how many people with schizophrenia have been failed by or fallen through the health care system and become criminal statistics.

Conclusion

A questionnaire was designed to examine the violent behaviour bought about by schizophrenia and how the families of those people with the illness were affected by it and coped with it. Accounts were provided of many lives dramatically affected by a tragic and misunderstood illness.

Many of those that completed the questionnaire had experienced violent behaviour from their relative with schizophrenia. The major conclusion which can be drawn from this study is that violence is a very real problem for the families of those with schizophrenia.

Some people are fearful that such findings justify locking people with schizophrenia away. They do not. They justify improvement in community services; early intervention to avert crises and adequate follow-up and maintenance of care. It may be idealistic to expect healthcare that is appropriate to everyones needs but there is something wrong with a system that caters for the needs of so very few.

If the experience of psychotic symptoms elevates the risk of violence and if psychotic symptoms can usually be controlled with treatment (Krakowski et al., 1986), then the provision of treatment to people in need of it can be justified as a small contribution to community safety, as well as a telling reflection on our common humanity. In otherwords, the majority of violent behaviour, from those with schizophrenia, is preventable if the present system of psychiatric care and aftercare was working as it should. This implicates the Government, lawmakers and health authorities in the violent behaviour by people with schizophrenia.

There is a need for honest reporting and research into schizophrenia and violence. The intention is not to heighten the stigmatization of the mentally ill or impend their progress in the community. It is to increase awareness and understanding of schizophrenia and, where possible, offer practical solutions.

People with schizophrenia may not be more dangerous than other people if their symptoms are being treated. Torrey (1983) suggests that most individuals with schizophrenia who commit acts of violence are not under treatment at all. Given the lack of follow up and aftercare for seriously ill mental patients released from hospital, it is no wonder that some of them commit acts of violence as a result of their illness. The only surprise is that more of them do not.

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APPENDICES

Appendix A

Schizophrenia and *Violence*

The majority of people with severe psychiatric illnesses live in the community. This is the result of government policy over the last thirty years toward deinstitutionalization. Often they receive less than adequate social support services while their families face the burden of care. Information from these families, about the situations with which they are coping, is frequently not heard nor given much credibility.

The following questionnaire has been designed to find out how family members are affected by and cope with violence from a schizophrenic relative. It also serves to examine the extent and kind of this behaviour.

If your relative has never displayed violent or threatening behaviour toward others or themselves, still fill out and return section one of the questionnaire. This information will help provide an accurate account of violence as it relates to schizophrenia.

The questionnaire is to be completed by a close relative or primary care-giving relative of a person suffering from schizophrenia. Consultation with other family members may also be useful. It concerns any stage of your relative's illness when he or she was violent and may cover a period when violence occurred before a diagnosis of schizophrenia was made. The violence does not have to be occurring now.

Please remember that there are no right or wrong answers. All that is asked for is your honesty and patience to fill out and return the questionnaire. Your response and insight will be most valuable.

SECTION ONE

The purpose of this section is to find out some facts about your relative who has schizophrenia. This section is applicable to all respondents even if your relative has never displayed or threatened violence.

(State his/her .....)

1 Sex. Male ❑
Female ❑

2 Age. (As at 1/7/93.) .....yrs.

3 Age when schizophrenic symptoms developed. .....yrs.

4 Age when schizophrenia diagnosed. .....yrs.

(Now please state.....)

5 How you are related to your mentally ill relative.
(Mother, husband, etc.)
.....

6 Whether your relative receives anti-psychotic medication for his/her schizophrenia. **YES / NO**

7 Whether your relative lives in a rural or urban area. **RUR. / URB.**

8 Does your relative live with you? **YES / NO / SOMETIMES**

9 Has your relative ever made threats of violence, acted in a threatening way, deliberately damaged property, been violent towards others or him/herself, or expressed violent or suicidal thoughts? **YES / NO**

If you answered yes, then please fill out the rest of the questionnaire.
If you answered no, then please complete and return section one only.

SECTION TWO

Threats of Violence

Please read the following list of behaviours. Tick the behaviours your relative has exhibited. Circle a number corresponding to the state of mind they were in at the time. (Select from the following categories.)

1 = Stable on medication.
2 = Stable on medication but under stress.
3 = Psychotic.
4 = Not known.
5 = Other. (Detail at bottom of page.)

- Threat to damage or destroy property ❑ **1 / 2 / 3 / 4 / 5**

- Threat to injure someone ❑ **1 / 2 / 3 / 4 / 5**

- Threat to kill someone ❑ **1 / 2 / 3 / 4 / 5**

- Threat with a weapon ❑ **1 / 2 / 3 / 4 / 5**

- Aggressive gestures or postures* ❑ **1 / 2 / 3 / 4 / 5**

*Aggressive gestures or postures = clenched fist, intimidating stance, etc.

List any additional behaviours you can think of that have not been covered. Also, include the state of mind they were in at the time.

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Is your relative's behaviour ongoing, episodic, made up of isolated instances, or something else? (Detail if something else.)

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SECTION THREE

Violence against Property

Please read the following list of behaviours. Tick the behaviours your relative has exhibited. Circle a number corresponding to the state of mind they were in at the time. (Select from the following categories.)

1 = Stable on medication.
2 = Stable on medication but under stress.
3 = Psychotic.
4 = Not known.
5 = Other. (Detail at bottom of page.)

- Damage to property* ❑ **1 / 2 / 3 / 4 / 5**

- Defacing of property* ❑ **1 / 2 / 3 / 4 / 5**

- Arson* ❑ **1 / 2 / 3 / 4 / 5**

*Damage to property = broken windows, damaged furniture, household effects, etc.
*Defacing of property = paintings, photos, walls, etc.
*Arson = house, buildings, clothes, etc.

List any additional behaviours you can think of that have not been covered. Also, include the state of mind they were in at the time.

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Is your relative's behaviour ongoing, episodic, made up of isolated instances, or something else? (Detail if something else.)

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SECTION FOUR

Violence against Others

Please read the following list of behaviours. Tick which behaviours your relative has exhibited. Indicate if the behaviour was directed at family or non-family. (Non-Family means people other than you and your immediate family such as flatmates, friends, doctors, and strangers.)
Circle the number corresponding to the state of mind they were in at the time. Select from the following categories.

1 = Stable on medication.
2 = Stable on medication but under stress.
3 = Psychotic.
4 = Not known.
5 = Other. (Detail at bottom of page.)

	Family	Non-Family	
- Minor assault*	❑	❑	1 / 2 / 3 / 4 / 5
- Mild assault*	❑	❑	1 / 2 / 3 / 4 / 5
- Major assault*	❑	❑	1 / 2 / 3 / 4 / 5
- Sexual assault	❑	❑	1 / 2 / 3 / 4 / 5
- Homicide	❑	❑	1 / 2 / 3 / 4 / 5

*Minor Assault = spitting, punching, kicking, slapping, grabbing, pulling, etc.
*Mild Assault = bruises, sprains, welts, etc.
*Major Assault: (With or without a weapon) = beaten up badly, broken bones, lacerations, hospitalisation, unconsciousness, etc.

List any additional behaviours you can think of that have not been covered. Also, include the state of mind they were in at the time.

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Is your relative's behaviour ongoing, episodic, made up of isolated instances, or something else? (Detail if something else.)

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SECTION FIVE

Violence against Oneself

Please read the following list of behaviours. Tick the behaviours your relative has exhibited. Circle a number corresponding to the state of mind they were in at the time. (Select from the following categories.)

1 = Stable on medication.
2 = Stable on medication but under stress.
3 = Psychotic.
4 = Not known.
5 = Other. (Detail at bottom of page.)

- Repetitive acts* ❑ **1 / 2 / 3 / 4 / 5**

- Mild injury* ❑ **1 / 2 / 3 / 4 / 5**

- Major injury* ❑ **1 / 2 / 3 / 4 / 5**

- Suicide attempt ❑ **1 / 2 / 3 / 4 / 5**

- Suicide ❑ **1 / 2 / 3 / 4 / 5**

*Repetitive Acts = picks or scratches skin, pulls hair, hits self repetitively, etc.
*Mild Injury = inflicts mild injury on self, bruises, sprains, cuts, welts, etc.
*Major Injury = inflicts serious injury on self, broken bones, lacerations, etc.

List any additional behaviours you can think of that have not been covered. Also, include the state of mind they were in at the time.

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Is your relative's behaviour ongoing, episodic, made up of isolated instances, or something else? (Detail if something else.)

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SECTION SIX

The following questions are medical and drug related questions.

(**NA** = Not applicable; **ST** = Sometimes.)

1 Does your relative receive anti-psychotic medication? **YES / NO**

If yes, does your relative receive medication by way of pill or injection? **PILL / INJ**

2 Does your relative comply with his/her prescribed drug routine ? **YES / NO / ST**

3 Does alcohol make your relative violent ? **YES / NO / ST / NA**

4 Do street drugs make your relative violent? **YES / NO / ST / NA**

The following questions are general questions about your relative.

5 Have you felt intimidated by your relatives actions? **YES / NO**

6 At what age was your relative first violent? .....yrs.

7 Does your relative direct his/her violence at one person in particular? **YES / NO**
If yes, at whom? Mother, father, spouse, etc. .....

8 Does your relative receive satisfactory community care? **YES / NO**

9 Does your relative persistently blame you and your family for his/her illness? **YES / NO**

SECTION SIX cont.....

10 Is there a pattern to his/her behaviour when violent ? **YES / NO**
If yes, please describe.

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11 Does the amount of contact you have with your relative affect the violence? **YES / NO**
If yes, in what way?

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12 Does the pattern of violence change with age? **YES / NO**
If yes, please describe.

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13 What type of violence is most disturbing and difficult to deal with for you and those concerned?

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SECTION SEVEN

Coping with Violence

The aim of this section is to find out how families cope with the violent situations that arise, as in threats of violence, violence against property and persons. Please list any strategies you use for coping with violence. For example do you confront situations, retreat, argue, fight back, ignore them, or use a combination of different techniques? Do you call the police, the hospital, or enlist other people's help? If nothing works for you, say so.

A Threats of Violence

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B Violence Against Property

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C Violence Against Others

D Violence Against Self

SECTION EIGHT

Effects of Violence

We are often asked about the effects of violence on the community but no one asks about the effects on the family. Please indicate the effects violence by your ill relative has had on your family. For example, the financial burden and cost of replacing or repairing damaged property, dealing with personal injury, and the emotional stresses and strains involved in caring for a person with schizophrenia who is violent.

SECTION NINE

Space is provided for you to include any relevant information you would like regarding any part of the questionnaire. For example, you may want to include additional information, note that a relevant question was not asked, or make general comments.

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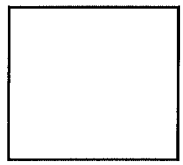
Thank you for your time.

Appendix B

Consent Form

This research is being undertaken by Chris Leafberg (B.Sc.). The information is being used to prepare a research report and involves answering a thirty to forty minute questionnaire. The study has the guidance, support and co-operation of the Schizophrenia Fellowship (NZ Inc.).

The questionnaire is voluntary and anonymous. You are not expected to answer any question you feel unable to answer. You should not put your name on it but instead tick the box as a sign of consent. All personal information given in this survey will be kept confidential and only the results made available.



Please return questionnaire and consent form by / /93

Chris Leafberg
University of Canterbury

Appendix C

Schizophrenia Fellowship

New Zealand Inc.
National Office
Tower Building,
Cnr. Salisbury / Montreal Sts, P.O Box, 593, Christchurch, New Zealand.
Telephone 64 - 3 - 366 1909, Fax 64 - 3 - 379 2322

16 August 1993

Dear Fellowship member,

The attached questionnaire on *Schizophrenia and Violence* is the follow-up to a workshop held during the 1991 annual conference of the Fellowship, and a working party set up by the National Council at the request of members of the AGM.

At the 1991 workshop, all family members present had first-hand experience of the destructive behaviour brought about by schizophrenia, and there was general agreement on the need for research into the subject. Unfortunately, most of the literature ignores the experiences of families. To overcome this gap, this investigation was so sought in order to provide accurate information as to the when and why of violent behaviour and, to seek and promote preventative measures wherever possible. To achieve this aim, completion and return of as many questionnaires as possible is most important.

If you are one of our members whose relative has received a changed diagnosis, and you wish to complete the questionnaire - please indicate clearly at the top of *Section One* the diagnosis of you relative, eg. schizo-affective disorder or manic depression.

To be really useful, the questionnaire needs to reach as many families as possible. So, we hope you will understand that we have used our scarce funds to achieve a wide distribution of the questionnaire, and have not enclosed a stamp for the return envelope. But, we do need to hear from you, whether or not the issue of violent or difficult behaviour is a problem for your family. Please spare us a stamp and let us have the benefit of your contribution towards this study.

Chris Leafberg has worked as a volunteer for the Schizophrenia Fellowship for several years and his hard work on this questionnaire has been supported by the working party and by the National Council of the Fellowship.

This is a significant area of research for people affected by schizophrenic illnesses and your prompt response will be much appreciated.

Yours sincerely,
Heather Simpson and Susan Noseworthy (National Co-ordinators)

Appendix D

Sample Profile

Alternative Diagnoses

Respondents were asked to give an alternative diagnosis if their relative did not have schizophrenia; 13 had manic depression, 13 had schizo-affective disorder, 8 had originally been diagnosed with schizophrenia but the diagnosis had since changed to manic depression (6) or schizo-affective disorder (2), 7 had a serious mental illness thought to be schizophrenia as yet undiagnosed, 4 had epilepsy and 1 was intellectually handicapped as well as having schizophrenia, 2 had schizophrenia in combination with a manic illness.

Sex and Age (400 / 414 responses = 96.39% / 99.76%)

The total sample was composed of 69.80% (289) males and 30.19% (125) females. The mean age of the total sample was 33.96 years for males and 36.25 years for females (2.75% (11) were less than 20 years old, 75.50% (302) were in between 20 and 40 years old, and 21.75% (87) were over 40 years old) (Figure 13).

Age Schizophrenia Developed and was Diagnosed (398 responses = 95.90%)

The symptoms of schizophrenia first appeared at 19.33 years of age on average in the total sample. Schizophrenia was diagnosed at 22.60 years of age on average in the total sample. The average length of time between the development of symptoms and a diagnosis of schizophrenia was 3.27 years for the total sample.

Anti-Psychotic Medication (411 responses = 99.04%)

In all, 89.78% (369) of the total sample received anti-psychotic medication for their illness, 8.76% (36) did not, and 1.46% (6) received it sometimes.

Rural or Urban Area (405 responses = 97.59%)

In all, 84.88% (342) of the total sample lived in urban areas, 13.58% (55) were situated ruraly, 1.48% (6) lived in a combination of rural and urban areas, and 0.49% (2) were currently institutionalized.

Relationship of Respondent (408 responses = 98.31%)

The majority of respondents were primary caregivers to their relative with schizophrenia. They were mothers, fathers, or spouses. Other respondents included sons-in-law, aunts, grandmothers, and siblings.

In all, 84.80% (346) of respondents were parents; 65.93% (269) were mothers, 15.20% (62) were fathers, and 3.68% (15) were mothers and fathers who jointly completed the questionnaire.

A further 6.86% (28) of respondents were siblings, 5.15% (21) were spouses, 1.47% (6) were children of parents with schizophrenia, 0.74% (3) were aunts, 0.49% (2) were mothers-in-law, 0.25% (1) were daughters-in-law, and 0.25% (1) were grandmothers.

Living arrangement (411 responses = 99.04%)

In all, 25.30% (104) of the total sample lived with their family, 27.74% (114) did so sometimes, and 46.96% (193) never did.

For respondents that were parents, 24.06% (83) of their relatives lived at home with them, 44.93% (155) did not, and 31.01% (107) did sometimes. For respondents that were spouses, 66.67% (14) of their relatives lived at home with them, 28.57% (6) did not, and 4.76% (1) did sometimes (Figure 14).

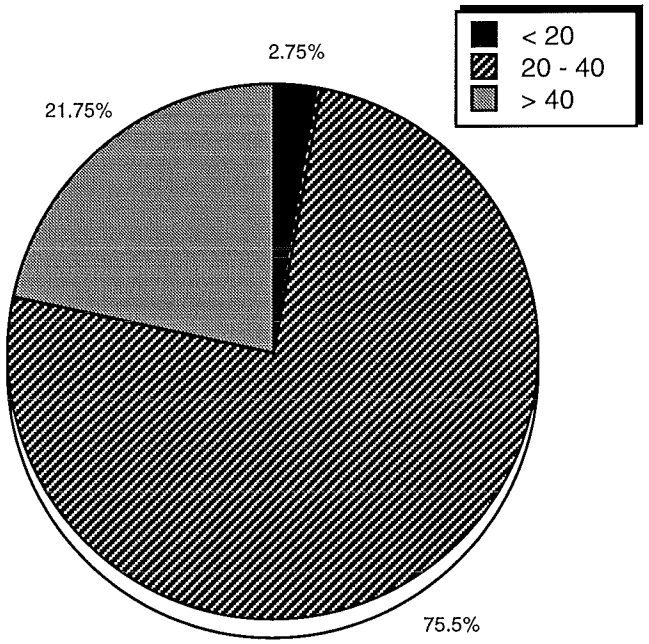


Figure 14. Age range of total sample.

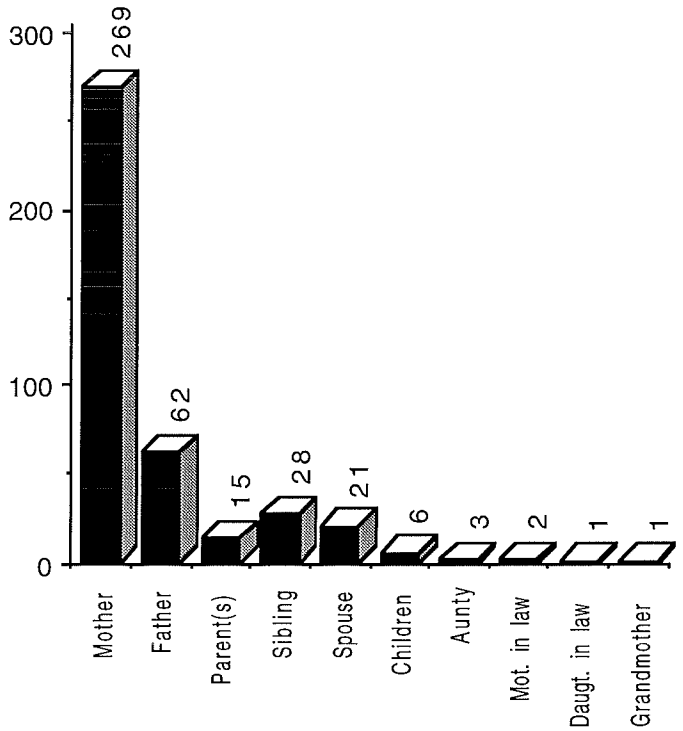


Figure 15. Relationship of respondent to relative with schizophrenia.